

# WELCOME TO OUR PRACTICE

We would like to welcome you as a new patient. We strongly believe in preventive and restorative care and have been fortunate enough to build a practice of patients who value their oral health.

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ SOC SEC # \_\_\_\_\_  
FIRST MI LAST  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
CHECK APPROPRIATE BOX:     MINOR    SINGLE    MARRIED    DIVORCED    WIDOWED  
EMPLOYER \_\_\_\_\_  
SPOUSE/PARENT NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ SOC SEC # \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?     YES     NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SOC SEC # \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ PHONE \_\_\_\_\_ GRP # \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?     YES     NO

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SOC SEC # \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ PHONE \_\_\_\_\_ GRP # \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR

\_\_\_\_\_  
DATE

**REGISTRATION**