



# Family & Cosmetic Dentistry

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## PATIENT REGISTRATION

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Sex:  Male  Female DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

If patient is a Minor, give Parent or Guardian's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Have any of your family members been seen in our office?  Yes  No If Yes please list family member name(s).

\_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Driver License #: \_\_\_\_\_ State: \_\_\_\_\_

Preferred method of contact:  Home Phone  Work Phone  Cell Phone  Text  Email

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. of years employed: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### RESPONSIBLE PARTY SPOUSE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Driver License #: \_\_\_\_\_ State: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. of years employed: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Primary Carrier Insured's Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Group #: \_\_\_\_\_

\*\*\* Our office does not file secondary Dental Insurance but will be happy to supply you with any information you need to file on your own. \*\*\*

I have filled out this form to the best of my knowledge:

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of patient, parent or guardian