Our goal is to help you achieve and **maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team. We will continue to warrant that trust as we serve your dental needs.**

Personal Profile **Date** ____ /____ /_____

First Name __________________________________ Middle Initial ______ Last Name _____________________________

I like to be called ____ □ Male □ Female

Date of Birth_______ /___ / ___ Age ______ Social Security #__________- ____ - ______ Driver's License # ______________

Address ____City ___________________State ______ Zip____________

Home Phone (_________) ___ ________________________ Work Phone (_________) _____________________Ext_______

Pager ___________________ E-mail _______________________________ Cell __________________ Fax________________

What number would you like us to call you on regarding your appointments?____

Name of Employer _______________________________________ Occupation _______________________________________

Address _______________________________________ __ City_________________________State ______ Zip ___________

Who may we thank for referring you to our practice? ____

Previous dentists name ____Phone (________)_________________________

Last seen by your previous dentist? _________________________ Treatment rendered ________________________________

Would you like us to contact your previous dentist for applicable records? □ No □ Yes

Account Information

Responsible Party's Name ____

Address ____City ___________________State ______ Zip ___________

Home Phone (_________) ___________________________ Work Phone (_________) _____________________Ext ______

Social Security # _________ - ____ - _______ Date of Birth_________ / ____ / ____ Driver's License # _________________

Insurance Information - Primary

Insurance Company Name ____

Address ____City ___________________State ______ Zip ____________

Insured's First Name__ ____________________________ Middle Initial _______ Last Name_____________________________

Social Security # _________ - ____ - _______ Date of Birth_________ / ____ / ____ Driver's License #__________________

Insurance Information - Secondary

Insurance Company ____

Address ____ City ___________________ State _______ Zip ____________

Insured's First Name ______________________________ Middle Initial _____ Last Name _____________________________

Social Security # _________ - ____ - _______ Date of Birth_________ / ____ / ____ Driver's License # _________________

Who should we contact in the unlikely event of an emergency:

Name ____Relationship to Patient ________________________________

Home Phone (_________)_____________________________ Work Phone (__________)_____________________ Ext _____

E-mail ____ Cell Phone (optional) ___________________________________

PATIENT REGISTRATION INFORMATION