PATIENT REGISTRATION
(PLEASE PRINT)

PATIENT NAME:_____
LAST FIRST MIDDLE

TITLE: Mr. Mrs. Ms. Miss Dr. HOME PHONE( )____-_____
WORK PHONE( )____-_____
WHAT NAME DO YOU GO BY?_____ CELL PHONE( )____-_____
SOCIAL SECURITY NUMBER_____-____-_____ BIRTHDATE ___-___-___
STREET ADDRESS_____
CITY_____STATE_____ZIP_____
EMAIL Address:_____
Employment information:(For children list responsible parent's information)
NAME_____ (Circle one: Patient, Mother, Father, Guardian)
HOME ADDRESS_____
EMPLOYER_____WORK PHONE( )___-____
BUSINESS ADDRESS_____
OCCUPATION_____BIRTHDATE __-__-__ SSN___-__-____
If you are filling this out for yourself, please give spouse information if married:
(For children, please give other responsible parent's information)
NAME_____ (Circle one: Spouse, Mother, Father, Guardian)
ADDRESS_____
EMPLOYER_____WORK PHONE( )___-____
BUSINESS ADDRESS_____
OCCUPATION_____BIRTHDATE __-__-__ SSN ___-__-___
Who is responsible for payment of this account:_____
How will payment be made?
CASH__ CHECK__ MASTERCARD__ VISA__ DISCOVER__ AMERICAN EXPRESS__

DENTAL INSURANCE INFORMATION FOR US TO HELP YOU OBTAIN BENEFITS

	PRIMARY	SECONDARY
INSURANCE CO NAME	_____	_____
INS CO PHONE NUMBER	_____	_____
CLAIM ADDRESS	_____	_____
SUBSCRIBER NAME	_____	_____
SUBSCRIBER SOC SEC #	_____	_____
SUBSCRIBER BIRTHDATE	_____	_____

What is the best time for your appointments? DAY_____ TIME_____
Are you available on short notice? Y N (M T W Th) (8AM-4PM)

How did you learn about the office or whom should we thank?

_____
Person to contact in case of emergency?_____
Relationship to patient:_____ PHONE:( )____-_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I understand that all charges incurred for dental care are my responsibility. I give my permission for Dr. Michelle Story and her staff to perform dental treatment on *(**please circle one**)*: myself my child.

DATE:_____ SIGNATURE:_____
(Signature of parent if patient is under 18)