

**REGISTRATION**

(Please submit driver's license or photo ID for insurance requirements along with dental insurance card when you have completed this form) Date \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Gender M  F  Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Number \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Best time to call \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME:  Same as Patient  Parent/Guardian Relation: \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Gender M  F  Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Number \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Best time to call \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Number \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Best time to call \_\_\_\_\_

**EMPLOYMENT INFORMATION**

The following is for:  Patient  Parent/Guardian  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**REFERRAL INFORMATION**

Name of person, office or other source referring you to our practice:  
\_\_\_\_\_