MICHAEL J. SPTIZER, D.D.S.
Patient Registration Form

PERSONAL INFORMATION

First Name _____ Last Name _____ Birth Date _____ /_____ /_____

Sex: Male Female Social Security # _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____

Email _____

Home Address _____ City _____ State _____ Zip _____

Employed by_____Occupation_____

Work Address _____ City _____ State _____ Zip _____

How did you happen to choose our office? _____ _____

Emergency Contact Name _____ Relationship _____Emergency Phone _____

Family Physician Name _____ Phone_____

DENTAL INSURANCE INFORMATION

Primary Carrier	Secondary Carrier
Insurance Co_____	**Insurance Co_____**
Group # _____	**Group#_____**
Employee _____	**Employee_____**
Employer_____	**Employer_____**
EMP. SOC. SEC.# _____	**EMP.SOC.SEC.#_____**
EMP. DOB_____	**EMP. DOB_____**

CONSENT FOR TREATMENT

I hereby grant complete authority to Dr.Spitzer to administer such anesthetics, analgesics, nitrous oxide, and to perform such dental procedure as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

Signature_____Date_____

(relationship to patient if patient is a minor or legal representative)