TODAY'S DATE_____

PATIENT REGISTRATION
DAVID A. GROAT, D.D.S.

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	NICKNAME OR PREFERRED NAME
EMAIL			
ADDRESS			BIRTHDATE
CITY	STATE	ZIP	☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN	
	EMAIL ADDRESS			
	ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)_____				

SPOUSE NAME

SPOUSE NAME	PHONE NUMBER ☐ PREFERRED	CELL NUMBER	☐ PREFERRED
ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PROVIDE FULL NAME	ARE THEY A PATIENT HERE? ☐ YES ☐ NO – CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ OUR WEBSITE ☐ BUILDING SIGN ☐ YOUR EMPLOYER ☐ MAILER/UNION HALL ☐ PUBLIC EVENT ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA ☐ DENTAL CENTER EMPLOYEE_____	

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

FINANCIAL INFORMATION CIRCLE ONE: PRIVATE PAY PRIVATE INSURANCE EMPLOYER INSURANCE