Dental Pointe
Quality dentistry for your family

PATIENT REGISTRATION

Responsible Party (Adult Responsable):

First Name: _____ Last Name: _____Middle Initial: _____

Birth date: _____ Social Security #: _____

Sex: ○ Female ○ Male

Address: _____Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____□ I would like to receive text confirmations

E-mail: _____□ I would like to receive email confirmations

Preferred Pharmacy: _____

Patient Information (Información de Paciente): (if someone other than the responsible party)

1) Patient is: □ Spouse □ Child □Other: _____

First Name: _____ Last Name: _____Middle Initial: _____

Birth date: _____

Sex: ○ Female ○ Male

2) Patient is: □ Spouse □ Child □Other: _____

First Name: _____ Last Name: _____Middle Initial: _____

Birth date: _____

Sex: ○ Female ○ Male

General Dentist Information (Dentista General):
Office Name: _____
Address: _____

_____
Phone Number: _____

Referred By (Referido Por):
○ Family/ Friend ○ Co-worker
Name: _____

○ Insurance Provider Search
○ Other: _____