## **REGISTRATION FORM**

Please complete the following section about the patien	<u>t:</u>
NAME:	NICKNAME:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
MAILING ADDRESS:	ST:ZIP:
HOME PHONE: WORK P.	HONE:
MAY WE CALL WORK TO CONFIRM APPOINTMENTS? [ ] YES	[ ]NO
Please complete the following section if you have dente	ıl insurance:
NAME OF THE INSURED:	DATE OF BIRTH:
WHERE DOES INSURED WORK?	SS#:
INSURED'S MAILING ADDRESS IF DIFFERENT THAN PATIENT'S:	
	ST:ZIP:
INSURED'S HOME PHONE: INSURED	S WORK PHONE:
MAY WE CALL WORK TO CONFIRM APPOINTMENTS? [ ] YES	[ ]NO
NAME OF INSURANCE COMPANY:	CERT/POLICY/GRP #
PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUS	SE [ ]CHILD [ ]OTHER
HAVE YOU USED YOUR DENTAL INSURANCE IN THE LAST 12 MON	THS? [ ]YES [ ]NO
	DATE OF BIRTH:SS#:
	CERT/POLICY/GRP#:
NAME OF PHYSICIAN:	PHONE:
PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUS	E [ ]CHILD [ ]OTHER
Please complete the following section if the patient is n	ot financially responsible or insured:
NAME OF PERSON TO BE BILLED:	DATE OF BIRTH:
MAILING ADDRESS:	ST:ZIP:
SOCIAL SECURITY NUMBER:	RELATIONSHIP TO PATIENT:
HOME PHONE: WORK P	HONE:
We would like to know:	
Whom should we notify in case of emergency?	
Relationship to patient:	Phone:
Whom may we thank for referring you?	