ESSENCE OF DENTISTRY

A New Dimension in Oral Health Care

PATIENT REGISTRATION

PATIENT NAME (Last, First, Middle Initial)			DATE OF BIRTH
ADDRESS			SOCIAL SECURITY NUMBER
CITY, STATE, ZIP			MARITAL STATUS ☐ Single ☐ Married
HOME PHONE	MESSAGE PHONE	CELL PHONE	SEX ☐ Male ☐ Female
PREFER ☐ Morning Appointment ☐ Afternoon Appointment			RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child
E-MAIL ADDRESS			WORK PHONE

OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

NAME	PHONE
ADDRESS	

REFERRED TO THIS OFFICE BY:

NAME	PHONE

INSURANCE INFORMATION

PRIMARY COVERAGE	SECONDARY COVERAGE
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION

UPDATED ON	SIGNATURE	DATE

INSURANCE CARD(S) AND DRIVER'S LICENSE