Patient Registration

Today's Date: ____/____/____

Patient First Name: _____ M.I. _____ Last _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (H): _____ (W): _____ (C): _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ SS#: _____ Driver's Lic: _____

Email: _____ **Appt Reminders via text?** ☐ Y ☐ N Via email? ☐ Y ☐ N

Employer: _____ Occupation: _____

Previous Dentist: _____ Last Seen: _____

How did you hear about us? ☐ Internet search ☐ Website ☐ Radio ☐ Printed Ad ☐ Phone Book; or

☐ Referred by: _____ ☐ Other: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

IF THE PATIENT IS A MINOR OR UNDER LEGAL GUARDIANSHIP - PLEASE COMPLETE SECTION BELOW

Responsible Party: _____ Relationship to patient: _____

Date of Birth: _____ SS#: _____ Driver's Lic: _____

Address: _____ City/State/Zip: _____

Phone (H): _____ (W): _____ (C): _____

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Employer: _____ Group#: _____

Subscriber Name: _____ Birthdate: _____ Relationship to patient: _____

Subscriber ID #: _____ Subscriber Address: _____

Secondary Insurance: _____ Employer: _____ Group#: _____

Subscriber Name: _____ Birthdate: _____ Relationship to patient: _____

Subscriber ID #: _____ Subscriber Address: _____

WINTERHOLLER
Dentistry & Implant Surgery