Patient Registration

All information is confidential.

Last Name: ______________________________ First Name: __________________________

Preferred Name: ____________________ Gender: ___________________

Address: ____________________________ City: _______________ Postal Code: __________

Date of Birth(D/M/Y): __________ Employer: ___________________ Marital Status: _________

Home Phone: ____________________________ Work Phone: ______________________________

Cell Phone: ______________________________ **E-mail**: ___________________________________

Parent/Guardian (if applicable): ________________________ Phone #: _______________________

Emergency Contact: __________________________________ Phone # ________________________

Person responsible for account: ____

Whom may we thank for referring you? ____

If you have any dental benefits please present card or numbers to admin team with this form.

Please note: Our office will be pleased to direct bill your insurance company on your behalf. However, Knowledge of your specific insurance coverage and maximums of coverage is your responsibility.

Date: ______________________________ Signature: _____________________________________