PATIENT REGISTRATION

Welcome to Dream Dental! Please, take a moment to complete this form. Please, ask us if you have any questions. Thank you!

Today's Date:_____

Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____

What You Prefer To Be Called:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Not Married

Date of Birth:_____ Age:_____ SSN:_____ Driver's Lic:_____

Address:_____

_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Occupation:_____

Referred By:_____ Employer:_____

What is your preferred way to communicate with us? ○ Email ○ Text ○ Phone ○ No Preference

Responsible Party *(if the patient is under 18 years old or the patient is not the insurance subscriber)*

First Name:_____ Last Name:_____ Middle Initial:_____

What You Prefer To Be Called:_____ Relationship to Patient:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Not Married

Date of Birth:_____ Age:_____ SSN:_____ Driver's Lic:_____

Address:_____

_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Occupation:_____

Emergency Contact Information

Whom should we contact?_____

Relation to Patient:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Print Your Name:_____ Signature:_____

Responsible Party Signature *(if patient is minor)*:_____