PATIENT REGISTRATION

Today's Date_____
Patient First Name: _____
Patient Last Name: _____
Patient Date of Birth: _____Male_____Female_____
Patient Social Security #: _____
Patient Address: _____
City, State, Zip: _____
Patient home phone#: _____
Patient cell phone #: _____
May we send you text messages? YES NO (circle one)
May we send you emails? Email address: _____
Emergency contact name and phone #: _____

IF THE PATIENT IS UNDER THE AGE OF 18

Responsible Party name: _____
Responsible Party date of birth: _____
Responsible Party Social Security #: _____
Responsible Party address if different from above: _____
City, State, Zip:_____
Responsible Party home phone if different from above: _____
Responsible Party cell phone if different from above: _____

IF YOU ARE NOT THE RESPONSIBLE PARTY PLEASE PROVIDE THE FOLLOWING
Name: _____
Address: _____
Home phone #: _____
Cell phone #: _____

****If you are not the guardian please provide proof that you have authority to authorize dental treatment.*** ***