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#: (_____) _____

Emergency Contact Name & 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. *

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HAPPY TOOTH
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