# PATIENT REGISTRATION

## PATIENT INFORMATION:

First Name:_____ Last Name:_____ M.I.__
Patient is: _____ Policy Holder Preferred Name:_____
_____ Responsible Party
Address:_____
City, State, Zip:_____
Address 2:_____
City, State, Zip:_____
Home Phone:_____Work Phone:_____Ext.___
Cellular:_____ Driver's License:_____
Birth Date:_____ Male:_____ Female:_____

## DENTAL INSURANCE:

Policy Holder for Patient (if other than patient:_____
**Responsible Party** (if someone other than patient):
First Name:_____ Last Name:_____ M.I.__
Address:_____
City, State, Zip:_____
Address 2:_____
City, State, Zip:_____
Home Phone:_____Work Phone:_____Ext.___
Cellular:_____ Driver's License:_____
Birth Date:_____ Social Security:_____

Date of Last Dental Exam?_____
Is there anything you would like to change about your smile?
_____

Any Dental Concerns or Discomfort?
_____

Are you interested in Whitening your smile?_____

How did you find out about Our Office?

_____