PATIENT REGISTRATION

Date: ______________

Patient Name: ____

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Home Address: ______________ (Street) City: ______________ Zip: ________ How Long? ____

Birth Date: __________ Age ____ Single ______ Married ______ Div. ______ Sep. ______ Widowed ______

Social Security #: ______________ California Driver's License #: ______________

Your Employer: ______________ Occupation: ______________ Years with firm: ________

Employer's Address: ______________ (Street) City: ______________ Zip ______________

Spouse's Name: ____

Spouse's Employer: ______________ Occupation: ______________ Years with firm: ________

Employer's Address: ______________ (Street) City: ______________ Phone: ______________

Nearest Relative Not Living with You ______________ (Name) Home Phone: ______________

______________ (Street) (City) (State) (Zip) Work Phone: ______________

Physician: ______________ (Name) (City) Date of Last Physical: ______________

Dentist: ______________ (Name) (City) Years: ______________

Referred By: ______________ City: ______________ Phone: ______________

Who is financially responsible for this bill? ______________________________

FOR PATIENTS WITH DENTAL INSURANCE

Primary Insurance ______________	Secondary Insurance ______________
Employer ______________	Employer ______________
Enrollee ID ______________	Enrollee ID ______________
Group Number ______________	Group Number ______________
First Name ______________	First Name ______________
Last Name ______________	Last Name ______________
Birthdate ______________	Birthdate ______________

I request and consent to treatment as necessary or desirable to the care of the patient first named above, including any necessary drugs, performance of operations, and laboratory, x-ray, or studies that may be used by the attending doctor or his assistant. Regardless of any estimated insurance coverage, I understand that any fees incurred will be my responsibility. I also certify that the above information is true and accurate.

Signed ______________________________
Signature of Patient or Parent/Guardian if Patient is under 18