Family Dentistry

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Patient Registration Form:

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐
Name:_____
first *middle* *last*
Date of Birth: _____ Age:____
mm/dd/yyyy
Address:_____
 # street *city* *province* *postal code*
Home Phone: (___)_____ Cell: (____)_____ Work: (_____)_____
Email: _____
In the future, may we confirm your appointments by email? Y or N
Employer Name_____ Employer Phone Number (___)_____ Family Physician_____ Physician Phone Number (___)_____
Your Spouse's Name _____
Your Spouse's Employer_____ Spouse's Employer Phone No.(___)_____

Emergency Contact

Name: _____ Phone: (____)_____ Relation: _____

Child Registration Form:

Name:____ *first* _____ *middle* _____ *last* _____

Date of Birth: _____ Age: ____
mm/dd/yyyy

School:_____ Grade: _____

☐ check if same as above Address:_____
 # street *city* *province* *postal code*
Home Phone: (___)_____ Cell: (____)_____ Work: (_____)_____

Is another family member a patient here at our office? *Y or N If yes,*

*Name*_____

Insurance Information

Primary Coverage ***Secondary Coverage***

Name of Insured_____ Name of Insured_____
Birthdate of Insured_____Birthdate of Insured_____
Primary Insurance Carrier_____ Secondary Insurance Carrier_____
Group/Policy Number_____Secondary Group/Policy Number_____
I.D. Number_____ Secondary I.D. Number_____
Division Number_____ Secondary Division Number_____
*x*_____ *(Signature of Patient/or Guardian)* _____*(date)*
*x*_____ *(Print name of Guardian)*