

PATIENT NAME:

David M. Glasscock
FAMILY PRACTICE OF DENTISTRY
PATIENT ADMISSION REGISTRATION

RECORD NUMBER _____

BIRTH DATE ____/____/____

PLEASE PRINT ALL INFORMATION CLEARLY

Today's Date ____/____/____

PATIENT'S SOCIAL SECURITY NUMBER _____

PATIENT NAME Last	First	Middle	TITLE (Circle) MRS. MS. MR. DR. OTHER _____
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DATE OF BIRTH MONTH DAY YEAR	SEX (Circle) FEMALE MALE
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HOME ADDRESS (Number, Street, Route, Etc.) _____

CITY	STATE	ZIP
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MAILING ADDRESS (If Different from Street Address) Number, Street, Box, Route, Etc. _____

CITY	STATE	ZIP
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HOME PHONE () -	WORK PHONE () -
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HOW WERE YOU REFERRED TO OUR OFFICE?

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME	DAYTIME PHONE () -
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ADDRESS (Number, Street, Route, Etc.) _____

CITY	STATE	ZIP
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RELATIONSHIP TO PATIENT (Husband, Wife, Mother, Father, Neighbor, Etc.) _____

PLEASE PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18 YEARS OF AGE OR HAS A LEGAL GUARDIAN

FATHER First	Last	OCCUPATION	DAYTIME PHONE () -
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MOTHER First	Last	OCCUPATION	DAYTIME PHONE () -
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MARITAL STATUS OF PARENTS
MARRIED SINGLE SEPARATED DIVORCED WIDOWED

WITH WHOM DOES PATIENT LIVE? _____

NAME OF LEGAL GUARDIAN First	Last	DAYTIME PHONE () -
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WHO DO WE CONTACT TO SCHEDULE APPTS?	DAYTIME PHONE () -	EVENING PHONE () -
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PLEASE CONTINUE ON REVERSE SIDE

WHO WILL BE RESPONSIBLE FOR PAYMENT?

NAME First		Last	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (If different from patient) Number, Street, Box, Route, Etc.				
CITY			STATE	ZIP
WHERE EMPLOYED			NUMBER OF YEARS EMPLOYED	
EMPLOYERS MAILING ADDRESS (Number, Street, Box, Route, Etc.)			DAYTIME PHONE () -	
CITY		STATE	ZIP	
PAYMENT METHOD (Check One)			DRIVERS LICENSE NUMBER	STATE
<input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> INSURANCE <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD				

PLEASE ANSWER THE FOLLOWING QUESTIONS IF THE PATIENT HAS DENTAL INSURANCE

WHAT IS THE RELATIONSHIP OF THE PATIENT TO THE POLICYHOLDER?

Self Spouse Child Other: Specify,

POLICY HOLDER'S NAME First		Last	SOCIAL SECURITY NUMBER	
POLICY HOLDER'S EMPLOYER			POLICY HOLDER'S DATE OF BIRTH	
EMPLOYER'S ADDRESS (Number, Street, Box, Route, Etc.)			EMPLOYER'S PHONE () -	
CITY		STATE	ZIP	
NAME OF INSURANCE COMPANY		ADDRESS TO SUBMIT CLAIMS (Number, Street, Box, Route, Etc.)		
		CITY	STATE	ZIP
POLICY/GROUP NUMBER OR NAME			POLICY HOLDER'S ID NUMBER	

PLEASE ANSWER THE FOLLOWING QUESTIONS IF PATIENT IS COVERED BY MORE THAN ONE INSURANCE POLICY

WHAT IS THE RELATIONSHIP OF THE PATIENT TO THE POLICYHOLDER?

Self Spouse Child Other: Specify,

POLICY HOLDER'S NAME First		Last	SOCIAL SECURITY NUMBER	
POLICY HOLDER'S EMPLOYER			POLICY HOLDER'S DATE OF BIRTH	
EMPLOYER'S ADDRESS (Number, Street, Box, Route, Etc.)			EMPLOYER'S PHONE () -	
CITY		STATE	ZIP	
NAME OF INSURANCE COMPANY		ADDRESS TO SUBMIT CLAIMS (Number, Street, Box, Route, Etc.)		
		CITY	STATE	ZIP
POLICY/GROUP NUMBER OR NAME			POLICY HOLDER'S ID NUMBER	

IS PATIENT'S DENTAL PROBLEM THE RESULT OF AN ACCIDENT? Yes No
 WORKERS COMPENSATION? Yes No