



**CURTISS  
DENTISTRY**

## PATIENT REGISTRATION

Date: \_\_\_/\_\_\_/\_\_\_\_\_

### *PATIENT INFORMATION*

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Prefers to be called \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Marital Status:  Married  Unmarried Gender:  Male  Female

### *ACCOUNT INFORMATION*

Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Social Security No. \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

### *DENTAL INSURANCE INFORMATION*

Primary Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's I. D. No. \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's I. D. No. \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_

### *GETTING TO KNOW YOU*

Is another member of your family our patient? Name \_\_\_\_\_

Relationship \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Person to contact in case of an emergency (other than spouse) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_