DR. MICHAEL PAGE
PATIENT REGISTRATION

Welcome to our practice and thank you for choosing us for your dental care. We ask that you please fill this form out as completely and as accurately as possible, so we will be able to serve you better. We want to assure you that all treatment recommended for you is based on your individual needs and is not influenced by insurance coverage. We pride ourselves on providing optimum dental care; any treatment we recommend for you would also be treatment we would recommend for a member of our own family.

Patient Information

Title: _____ Full LEGAL Name: ____
What would you prefer to be called: __________________________ Gender: Male Female
Birthdate: _________________ Social Security #: ________________________
Marital Status: Single Married Divorced Widowed Spouse's Name: ________________
Address: _______________________________________ Apt/Suite: _______________
City: _____________________ State: __________ Zip Code: _________
Phone: Home: ____________________ Work: _________________ Cell: _________________
Email: ____ Best place to contact you: ________
Employer: _____________________________ Occupation: ____________________________
Referred by:____

Person Responsible for Account

Title: _____ Full LEGAL Name: ____
Relationship to patient: Self Spouse Parent Other_________________
Birthdate: _________ Social Security #: ________________ Driver's License #: ___________
Address: _______________________________________ Apt/Suite: _______________
City: __________________ State: ________ Zip Code: _________
Phone: Home: _________________ Work: ______________ Cell: _________________
Email: __________________________ Best place to contact you: _______________________
Employer: _________________________________ Occupation: ________________________

Dental Insurance Information

(Please fill out completely and provide copy of insurance card)

Primary Insurance
Insurance Carrier:___________________________
Insurance Phone: ___________________________
Employer: _________________________________
Employee: ________________________________
Birthdate: ___________________________
Social Security #: __________________________
Relationship to patient: Self Spouse Child
Other______________

Secondary Insurance
Insurance Carrier:_________________________
Insurance Phone: _________________________
Employer: _______________________________
Employee: _______________________________
Birthdate: __________________________
Social Security #: ____________________
Relationship to patient: Self Spouse Child
Other_________________

Emergency Contact Information

Name: ______________________________________ Relationship to patient: ______________
Phones: Home: ___________________ Work: ______________ Cell: ____________________