Holland *family* Dentistry
REGISTRATION FORM

PATIENT INFORMATION (CONFIDENTIAL)

Name ____ Date ____________________

First MI Last

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address ______________________________ City__________ State __________ Zip________

Home Phone ____________________________ Cell Phone ______________________________

Date of Birth ________________ SS # ________________ Driver's License # ____________________

If College Student, F.T/P.T., Name of School ____________________________ City __________ State________

Patient's or Parent's/Guardian's Employer ______________________________ Work Phone ________________

Business Address ____________________________ City ____________ State ________ Zip ________

Spouse or Parent's/Guardian's Name __________________ Employer______________ Work Phone __________

Whom may we thank for referring you? ____

Person to contact in case of an emergency ____________________________________ Phone ______________

PERSON RESPONSIBLE FOR THIS ACCOUNT (if different from above)

Name________________________ Relationship__________________________ Phone______________

Address________________________City __________________ State ________________ Zip ________

Date of Birth______________ SS#______________ Driver's License#______________________

INSURANCE INFORMATION

Primary:

Name of Insured ____________________________ Relationship to Patient __________________________

Date of Birth of Insured______________ SS#____________ Date of Employment______________________

Name of Employer__________________________ Insurance Co. ________________________

Group #____________________________

Secondary:

Name of Insured ____________________________ Relationship to Patient __________________________

Date of Birth of Insured______________ SS#____________ Date of Employment______________________

Name of Employer__________________________ Insurance Co. ________________________

Group #____________________________

Preferred Method of Contact:

__Text (Cell #)________________

__Email (Address)______________@__________

__Phone (Cell/ Home #)__________________________

__Postcard/ Mail______________________________

X________________________________ ________________________ __________

SIGNATURE OF PATIENT or Minor PARENT/GUARDIAN **Relationship to Patient** **Date**