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 # _____ E-Mail Address _____

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#_____

INSURANCE INFORMATION

Primary:

Name of Policy Holder_____ Relationship to Patient _____

Date of Birth of Insured_____ SS#_____ Date of Employment_____

Name of Employer_____ Insurance Co. _____ Group # _____

Secondary:

Name of Policy Holder _____ Relationship to Patient _____

Date of Birth of Insured_____ SS#_____ Date of Employment_____

Name of Employer_____ Insurance Co. _____ Group # _____

PREFERRED METHOD OF CONTACT:

_____ Text _____Email _____Phone _____Postcard/Mail

X_____ _____ _____

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