PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Ext: _____ Mobile Phone: _____

Birthdate: _____/____/_____ Age: _____ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Sex: ◯ Male ◯ Female Social Security: _____-_____-_____ Driver's License: _____

Email: _____ ◯ I would like to receive correspondence via e-mail.

Emergency Contact: _____ Relationship to Patient: _____ Number: _____

Responsible Party (If not the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Ext: _____ Mobile Phone: _____

Birthdate: _____/____/_____ Social Security: _____-_____-_____ Driver's License: _____

Preferred Pharmacy: _____ Phone Number: _____

DENTAL Primary Insurance Information

Name of Insured: _____

Insured Soc. Sec: _____ DOB: _____

Employer: _____Insurance Co: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Group #: _____ Member ID: _____

DENTAL Secondary Insurance Information

Name of Insured: _____

Insured Soc. Sec: _____ DOB: _____

Employer: _____Insurance Co: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Group #: _____ Member ID: _____

Reason for your visit today?

_____

_____

What is your main concern in having dental treatment?

_____

_____

How did you hear about our office?

◯ Family/Friend ◯ Internet ◯ Referred (if yes, please list) _____

I give my permission for Dr. Maleki to use my photographs, radiographs, and models in any presentation to any individual or group. This would include possibly posting before and after pictures on Dr. Maleki's website; www.grayhawkprosthodontics.com.

Signature_____ Date: _____