



Patient Registration

Patient Information

Name: _____ (_____) Social Security #: _____
Last Name First Name Preferred Name

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ E-mail: _____

Sex: Male Female Birthdate: _____ Age: _____ Single: Married: Widowed: Separated: Divorced:

Employer: _____ Occupation: _____

Work Address: _____ Phone: _____
Street City State Zip

Name of School (If Patient Is A Student): _____ Full Time Student: Part Time Student:
Appointment Time Preference:
No Preference: Prefer AM: Prefer PM:

Emergency Contact: _____ Phone: _____

How did you hear about us or who may we thank for referring you? _____

Primary Dental Insurance

Policy Holder: _____
Last Name First Name Date of Birth Relationship to Patient

Address (if different from patient): _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____
City State Zip

Insurance Company: _____ SS or ID#: _____ Group #: _____

Additional family members under this plan: _____

Additional Dental Insurance

Policy Holder: _____
Last Name First Name Date of Birth Relationship to Patient:

Address (if different from patient): _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____
City State Zip

Insurance Company: _____ ID/SS #: _____ Group #: _____

Additional family members under this plan: _____

I certify that the above information is true and correct to the best of my knowledge.

I agree to notify Glacier Lake Dental of any changes in the above information and/or my health status.

X

Signature of Patient, Parent or Guardian

Date