



PATIENT REGISTRATION

Welcome to Dream Dental! Please, take a moment to complete this form. Please, ask us if you have any questions. Thank you!

Today's Date: _____

Patient Information

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

What You Prefer To Be Called: _____

Sex: Male Female Marital Status: Married Not Married

Date of Birth: _____ Age: _____ SSN: _____ Driver's Lic: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Referred By: _____ Employer: _____

What is your preferred way to communicate with us? Email Text Phone No Preference

Responsible Party *(if the patient is under 18 years old or the patient is not the insurance subscriber)*

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

What You Prefer To Be Called: _____ Relationship to Patient: _____

Sex: Male Female Marital Status: Married Not Married

Date of Birth: _____ Age: _____ SSN: _____ Driver's Lic: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Emergency Contact Information

Whom should we contact? _____

Relation to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Print Your Name: _____ Signature: _____

Responsible Party Signature *(if patient is minor)*: _____