Welcome to Infinity Dental

# Patient Registration

**TODAY'S DATE**____________

| **Patient's Name** | **Birthdate** | **Age** | **Sex:** M F |
|---|---|---|---|
| **Home Address** | **City** | **State** | **Zip** |

| **Home Phone #** | ***Please Circle One:*** Single, Married, Separated, Widow | **Your Social Security Number** |
|---|---|---|
| **Your Employer** | **Occupation** | **Work Phone #** |

| **Are you a full time student?** Yes No | *If patient is minor we need Mother & Father's Names & Birthdate* |
|---|---|

| **Person responsible for account:** | **YOUR Driver's License Number:** | |
|---|---|---|
| **Name of spouse ( or parent if minor)** | **YOUR E-mail address** | **YOUR cell phone #** |

| **Spouse's ( or parent's) employer** | **Spouse's Soc. Sec. #** | **Work phone #** |
|---|---|---|

**EMERGENCY INFORMATION**

*Name, Address, & Telephone of a relative not living with you:*

**How did you hear about our office?**

**Reason for this visit?**

| **DENTAL INSURANCE INFORMATION (Primary Carrier)** | | | **If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)** | | |
|---|---|---|---|---|---|
| **Insured's name** | **DOB** | **SS#** | Insured's name | DOB | SS# |
| **Insured's employer** | | | Insured's employer | | |
| **Insurance Co** | | | Insurance Co | | |
| **Insurance Co Address** | | | Insurance Co Address | | |
| **Phone #** | | | Phone # | | |
| **Group #** | **Policy #** | | Group # | | Local # |

Is there anything else about your medical or dental history we should know?

| Patient Signature (or parent of child) | Date | Doctor's Signature |
|---|---|---|

I have received/read a copy of the HIPPA Policy: ______
Initial