Patient Registration

Patient Information

Patient: ____

Mr./Mrs./Ms. First Name M. I. Last Name "Goes By"

If a Child, Father's Name ______________________ Mother's Name ______________________

Address ____

Address Apt. # City State Zip

Home Phone # ____________ Work # ____________ Cell # ____________

Where & when are the best times to reach you? ____________ May we call you at work or on your cell? ______

Birth date ________ Male ___ Female ___ SS# ____________ Full time student? Yes ___ No ___

Employer ______________________ Occupation ______________________

Employer Address ____

Address Apt. # City State Zip

What are some of your hobbies and interests? ______________________________

How did you learn about our office? Friend ____ Family ____ Healthcare/Dental Provider ____ Yellow Pages ____

Business Acquaintance ____ Website ____ Other ____ Whom may we thank? ______________

Email address ____

Spouse Information

Name ______________________ Combined Account? Yes ____ No ____ Work# ______________

Employer ______________________ SS# ______________ Birth date ______________

Account Information

Person Responsible ______________________ Relationship to Patient ______________

Home Phone # ____________ Work # ____________ Cell # ____________

Address ____

Address Apt. # City State Zip

Birth date ______________ SS# ______________

Insurance Information

Insured Party ______________________ Relationship to Patient ______________

Birth date ______________ SS# ______________ Employer ______________

Insurance Company ______________________________ Phone # ______________

I confirm that all questions have been answered truthfully. I agree to be responsible in full (regardless of dental insurance involvement) for all fees for service provided by the office.

Responsible Person's Signature ______________________ Date ______________

James B. Polley, D.D.S.

Trusted Dental Care