St. Mary's 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 a minor we need Mother & Father's Names & Birthdates	

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 social Security #	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)			Secondary Insurance Carrier		
Insured's name	DOB	SS#	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Company			Insurance Company		
Insurance Company Address			Insurance Company Address		
Phone #			Phone#		
Group #	Policy #		Group #	Policy #	

May we contact you by: ☐ Text Message ☐ Email ☐ Both ☐ None	Is there anything else about your medical or dental history we should know?

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