The Main Street Dentists

DENTAL REGISTRATION FORM

PATIENT INFORMATION

Name____ ____________________
Last First Middle Soc Security #

Address____

City__________________________________State________________Zip___________

Home Phone________________ Cell Phone__________________ Email__________________

Sex ☐ M ☐ F Age_______ Birthdate________________ Married ☐ Widowed ☐ Single ☐
Divorced ☐ Partnered ____years

Spouse/Partner Name______________________________ Cell # ______________________

Emergency Contact_____________________Relationship_____________ Contact #_____________

Whom May We Thank for Referring You________________________________

RESPONSIBILITY PARTY (complete only if different from patient))

Guarantor Name____________________________ Soc. Security #______________________

Address____________________________ Phone #____________ Cell #_________________

City__________________________________ State______________ Zip______________

Place of Employment____________________________ Work #___________________________

DENTAL INSURANCE INFORMATION

Insurance Name____________________________ Subscriber SSN or ID#____________________

Subscriber DOB_____________________ Ins. Contact #___________________________________

Insurance Company__________________________________ Group #_____________________

Is Your Visit Due to A Job-Related Injury or Automobile Accident? Yes ☐ No ☐

I authorize the release of any medical information necessary to process this bill and assume all financial obligations for all dental treatment and services agreed and provided by **The Main Street Dentists.**

____ ____________________
Signature of Patient, Guardian or Responsible Party Date

Rev 06/22