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 08/21