CARTER AND HOFF DENTISTRY

PATIENT REGISTRATION:

Today's Date_____ Patient's Full Name_____

Prefers to be call by_____

Street Address_____ City_____ State____ Zip_____

Mailing Address_____ City_____ State____ Zip_____

Home Phone #_____ Cell #_____ Work #_____

Patient's Employer/School_____ Email_____

Patient's Date of Birth_____ Age_____ Male____ Female____

Married____ Single____ Widowed____ Divorced____ Separated____

Social Security #_____ Driver's License Number_____ State____

Emergency Contact_____ Phone_____

Relationship_____ Referred by_____

Preferred Pharmacy and Location_____ Phone_____

DENTAL INSURANCE:

Primary Insurance Company_____ Effective Date_____

Subscriber's Name_____ Subscriber's Date of Birth_____

Subscriber's Employer_____ Social Security #_____

Relationship to Patient_____

Group #_____ ID# (if different from SS#)_____

Secondary Insurance Company_____ Effective Date_____

Subscriber's Name_____ Subscriber's Date of Birth_____

Subscriber's Employer_____ SS#_____

Relationship to Patient_____

Group #_____ ID# (if different from SS#)_____

*We do not file third insurance companies; however, you are welcome to do so.

RESPONSIBLE PARTY:

*This must be only one person, and this person must be present and sign this form.

Name_____ Relationship to Patient_____

Social Security #_____ Driver's License #_____ State____

Street Address_____ City_____ State____ Zip_____

Mailing Address_____ City_____ State____ Zip_____

Home Phone #_____ Cell #_____ Work #_____

Responsible Party Signature_____ Date_____