ILMINGTON
Holistic Dentistry

Patient Registration Form

First Name _____ Last Name _____ MI ___ Date _____
Street Address _____ Home Phone _____
City, State and Zip _____ Work Phone _____
Email Address _____ Cell Phone _____
Birth Date _____ Age _____ Social Security Number (if necessary)_____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Employment: Full-Time Part-Time Retired Employer Name _____
Employer Address _____
Student: Full-Time Part-Time School Name _____
Spouse's Name _____ Spouse's Work Phone _____
Emergency contact _____ Emergency contact's number _____
Physician's Name _____ Physician's Phone _____
Preferred Pharmacy _____ Pharmacy Phone (if known) _____
Reason for Visit _____
Do you require pre-medication prior to dental treatment? No Yes _____
How did you learn of our office? _____

Responsible Individual (if other than the patient):

First Name _____ Last Name _____ MI ___ Date _____
Street Address _____ Home Phone _____
City, State and Zip _____ Work Phone _____
Birth Date _____ Social Security Number (if needed for insurance company)_____
Relationship to Patient _____
Employment: Full-Time Part-Time Retired Employer Name _____
Employer Address _____

Insurance Information (if applicable):

Name of Policy Holder (if different from Responsible Individual) _____
Policy Holder Birth Date _____ Age _____ Social Security Number _____
Employer Name and Address _____
Insurance Company _____ Group # _____
Insurance Company Address _____
Relationship to Patient _____ Is the patient covered under more than one dental plan? Yes No

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The above information is accurate and complete to the best of my knowledge.

Signature (patient or responsible individual) _____ Date _____