PRAIRIE LAKES DENTAL P.A.

PATIENT REGISTRATION FORM

Patient's First_____MI_____Last_____ Date of Birth_____

Responsible Party_____ Policy Holder Name_____

Address_____

Home Phone #_____ Cell Phone #_____

Sex M or F Social Security #_____ Driver's License #_____

Email Address_____

Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widowed☐ Spouse Name_____

Employer_____ Occupation_____

Work Phone #_____

In Case of Emergency, call_____ Phone #_____Relationship_____

How did you hear about our office?_____

Previous Dental Office_____

PARENT/GUARDIAN INFORMATION

Name_____ Date of Birth_____

Address (if different from above)_____

Home Phone #_____ Cell Phone #_____ SSN_____

Employer_____ Occupation_____

Work Phone #_____

IF YOU HAVE DENTAL COVERAGE, PLEASE BRING YOUR INSURANCE CARD ON YOUR APPT. DATE.