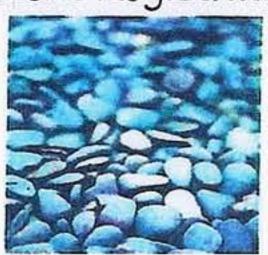
Vintage Dental Spa Patient Registration



Patient information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print) Name Last Middle Initial Address City State Zip ____ Sex:

Female

Male Birthdate email Cell Phone (___)____ Work (___)___ Home Phone () ☐ Home work Do you prefer to receive calls at: ☐ Cell ☐ No Preference ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Partner for years ☐ Divorced Patient Employer/School _____Occupation ____ Employer/School Address _____ City _____ State ___ zip Spouse or parent's name _____ Employer____ Work Phone () Person to contact in case of emergency _____ Phone (How did you hear about us? ☐ Insurance ☐ Billboard ☐ Ad Pages ☐ Internet ☐ Phone Book ☐ Mailer Patient/Friend □ Other Responsible party Name of person responsible for this account Relationship to patient _____ Phone () Address City ____ State ___ Zip ____ Work Phone (____)____ Name of employer _____ Insurance information Name of insured ______Relationship to patient _____ Birthdate Social Security # _____ Date employed _____ Name of employer ______ Work Phone () Address _____ City ____ State ___ Zip _____ Insurance Co. _____ Group # ____ Employer # _____ DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING: Name of insured _____ Relationship to patient _____ Birthdate ______ Social Security # _____ Date employed _____ Name of employer _____ Work Phone (____) Address _____ City ____ State ___ Zip ____ Insurance Co. _____ Group # ____ Employer # _____