FAX: 608-781-3998

**HOW DID YOU HEAR ABOUT OUR OFFICE?** ________________________

# PATIENT REGISTRATION FORM

Please complete the following confidential information:

Patient or responsible party, if patient is a minor:

Name (first, middle initial, last): ______________________________
Home Address (street, city, state, zip): ______________________________
Employer: ______________________________
Business Address: ______________________________
Occupation: ____________ Birth date: ____________ Age: ________
Home Phone #: ____________ Work Phone # / Ext: ____________

Spouse:

Name (first, middle initial, last): ______________________________
Home Address (street, city, state, zip): ______________________________
Employer: ______________________________
Business Address: ______________________________
Occupation: ____________ Birth date: ____________ Age: ________
Home Phone #: ____________ Work Phone # / Ext: ____________

Child: (if child is the patient)

Name (first, middle initial, last): ______________________________
Home Address (street, city, state, zip): ______________________________
Home Phone ____________ Birth date: ____________ Age: ________
School: ____________ City: ____________ Grade: ________

Dental Insurance:

Primary Insurance Company: ______________________________
Address (street, city, state, zip): ______________________________
Employee Name: ____________Soc. Sec. No.: ____________
Member #: ____________ Group #: ________ Tel #: ________

Secondary Insurance Company: ______________________________
Address (street, city, state, zip): ______________________________
Employee Name: ____________Soc. Sec. No.: ____________
Member #: ____________ Group #: ________ Tel #: ________

Credit Card: (Please list at least one of the following: VISA/MasterCard/AMEX/Discover)

| | Card | Acct# | Name on Card | Exp. Date |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

PERSON TO CONTACT IN CASE OF EMERGENCY:
Name: ______________________________ Phone #: ____________
Address: ______________________________

Is another member of your family a patient at our Practice? YES NO
If yes, what is their name? ______________________________