AMHERST DENTAL GROUP PATIENT REGISTRATION

Date_____/_____/_____

Patient name_____ _____ _____
First Middle Last

Date of Birth_____/_____/_____ Age_____ Male□ Female□

Single□ Married□ Long-Term Partner□ Separated□ Widowed□ Divorced□

If a child, accompanying parent's name: _____

Address_____
City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell_____
Preferred phone # to be confirmed: home□ work□ cell□
Email_____
Please check box if you would you like email / text confirmation for appointments. Email: □ Text: □

Social Security #_____
Employer_____
Address_____
City_____ State_____ Zip _____
Present Position_____ How long held_____

If a college student: F/T□, P/T□ Name of School_____

Purpose of initial visit_____
Referred by_____

Dental Insurance:

Primary_____ Secondary_____
Address_____ Address_____
City_____State_____Zip_____ City_____State_____Zip_____
ID#_____ ID#_____
Group#_____ Group#_____
Policy Holder_____ Policy Holder_____
Date of Birth_____/_____/_____ Date of Birth_____/_____/_____
Relationship To Patient_____ Relationship To Patient_____
Employer_____ Employer_____

Emergency Contact

_____ _____
First Last
Phone: Home_____Work_____ Cell_____
Email_____