DORES DENTAL
DR. JAMES DORES, DMD

Welcome

Patient Registration Form **Today's Date**_____

Patient Name _____ Preferred Name _____

Birth Date _____ Age _____ Sex ☐ M ☐ F

SS# _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address _____

City _____ State _____ Zip Code_____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer_____

Person Responsible (If other than patient)

Name _____ Birth Date _____ SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer_____

Emergency Contact

Name _____ Relationship _____

Address_____ Phone _____

How did you hear about our office?

☐ Billboard ☐ Mail Piece ☐ Radio ☐ TV ☐Internet

Friend (please specify) _____

Other (please specify) _____

Referring Dentist or Orthodontist name _____

Dental Insurance - Primary

Insured's Name _____

Insured's DOB _____

Insured's SS# _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

ID# _____

Dental Insurance - Secondary

Insured's Name _____

Insured's DOB _____

Insured's SS# _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

ID# _____

Dental History

What would you like us to do today?_____

Are you in dental discomfort today? _____

Former Dentist_____ Address _____

Phone _____ Date of last dental care _____

_____

Signature

Rev. 7/12/2017