Anthony R. Cardoza, DDS

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

HOME PHONE # | CELL #

BIRTH DATE | AGE | MALE | FEMALE

MARRIED | SINGLE | DIVORCED | WIDOWED

SOCIAL SECURITY # | DRIVER'S LICENSE #

EMAIL

LAST NAME (CHILD) | FIRST | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE # | CELL #

BIRTH DATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY # | DRIVER'S LICENSE #

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS. FILL IN THE BOX ALSO

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP #

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. #

INSURED'S SOCIAL SECURITY #

SECONDARY CARRIER

INSURANCE COMPANY

GROUP #

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. #

INSURED'S SOCIAL SECURITY #

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE #

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE #

ADDRESS

CITY | STATE | ZIP

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY #

ADDRESS

CITY | STATE | ZIP

PHONE #

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE # | FAX #

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE # | FAX #

Please turn over and sign