Matta Family Dentistry

Patient Registration

Patient Name: _____ **Social Sec#:** _____

Address: _____ **Email:** _____

City, State & Zip: _____

Home Phone: _____ **Cell Phone:** _____

Sex: ☐ **M** ☐ **F** ☐ **Other:** _____ **DOB:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Child**

Patient employed by: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

Whom may we thank for referring you? _____

Emergency Contact: _____ **Phone:** _____

_____

Primary Insurance

Subscriber Name and DOB: _____

Subscriber Address: _____

Relationship to Patient: _____ **Social Sec#**: _____

Insurance Co Name / Address: _____

Subscriber ID #: _____ **Group #:** _____

_____

Secondary Insurance

Subscriber Name and DOB: _____

Subscriber Address: _____

Relationship to Patient: _____ **Social Sec#**: _____

Insurance Co Name / Address: _____

Subscriber ID #: _____ **Group #:** _____

_____

Dental History

Reason for Today's Visit: _____

Date of last dental visit: _____ **Date of last X-Rays:** _____