CRISTEL
FAMILY DENTISTRY

Registration Form

Patient Name: Last First Middle Marital Status Birth Date Social Security #

Address: Street and/or PO Box City State ZIP

Cell Phone # Home Phone # Email Address

Place of Employment Position City State Business Phone #

Spouse Name: Last First Birth Date Phone # Social Security#

Spouse's Employer Position City State Business Phone #

Financially Responsible Party

IN CASE OF EMERGENCY, Please notify:

Name Relationship Phone #

Who may we thank for referring you to our office today?_____

INSURANCE INFORMATION

Name of Dental Group Plan Address Group # Local Union #

Employee Employee # Social Security # Birth Date

Other Group Dental Insurance

Name of Group Dental Plan Address Group # Local Union #

Employee Employee # Social Security # Local Union #

I authorize payment of my dental benefits directly to the attending dentist. I understand I am financially responsible to the dentist for any chargers not payable by my dental plan.
To avoid a missed appointment fee we require a 24 hour notice for appointment changes or cancellations.

Signature: _____ Date: _____