Welcome to Gold Canyon Dentistry

REGISTRATION FORM

Patient Information

Name:____ I Prefer to be called: ________________________

Address:____City:________________________State:_________________Zip____________

Phone (_____)______________ Work Phone (____) _____________ Cell Phone (_____)________________

The best time to contact me is:_______________ ▯ A.M. ▯ P.M. on my ▯ Home phone ▯ Work phone ▯ Cell phone

Date of Birth:____________ Social Security Number:_____________________

Check Appropriate Box: ▯ Minor ▯ Single ▯ Married ▯ Widowed ▯ Separated ▯ Divorced

If Student, Name of School________________________ City/State_______________________ ▯ FT ▯ PT

Spouse or Parent's Name:________________________ Employer_______________ Work Phone______________

Whom may we thank for referring you? ____

Person to contact in case of emergency______________________________ Phone_____________________

Email Address__________________________________

Responsible Party

Relationship to Patient: ▯ Self ▯ Spouse ▯ Parent ▯ Other

Name:____ Relationship to Patient: _________________________

Address:____

City:________________________________ State:______________ Zip:_____________ Phone: (___)_________________

Employer____________________ Work Phone (___)______________ SSN#_____________________________

Insurance Information (Give copy of card(s) to front desk)

Name of Insured__________________________DOB_________________Relationship to Patient ___________________

SSN#:_________________________ Name of Employer:____________________________

Employer Name:___________________________ Insurance Co_________________________ ID#_________________________

--------DO YOU HAVE ANY ADDITIONAL INSURANCE? ▯ Yes ▯ No
IF YES, COMPLETE THE FOLLOWING -------

Name of Insured_________________________________DOB__________________Relationship to Patient ___________________

SSN#:_____________________ Name of Employer: _________________________ Insurance Co____________________________

ID#________________________