Santiago Dental Wellness

SEDATION. IMPLANTS. AESTHETICS.

# PATIENT REGISTRATION

Patient Name _____ Birthdate _____ Age _____ **Sex: M / F**

Home Address _____ City _____ State _____ Zip _____

Your Cell # _____ Your Soc Sec # _____ /_____ /_____

Driver's License # _____ Email Address _____

Your Employer _____ Occupation _____ Work # _____

Please Circle: Single Married Separated Widow(er)

Are you a full-time student: Y / N

*if patient is a minor, Mother's Name & Birthdate* _____ *Father's Name & Birthdate* _____

Person responsible for account _____

Name of Spouse/Significatn Other: _____ Their cell # _____

## Emergency Contact Information

Name, Address, & Phone # _____

How did you hear about our office? _____

Reason for this visit? _____

_____

| Dental Insurance Information (Primary Carrier) | If you have a dual insurance coverage, eomplete this for the second coverage (this office bills primary ins only) |
|---|---|
| | |
| Insured's Name DOB SS# | Insured's Name DOB SS# |
| Insured's employer | Insured's employer |
| Insurance Co | Insurance Co |
| Insurance Co Address | Insurance Co Address |
| Phone # | Phone # |
| Group # Policy # | Group # Local # |

**Patient Signature** _____ **Date** _____