

# *DIAMONDSMILES* Patient Registration

Patient Name \_\_\_\_\_ Telephone (H) \_\_\_\_\_  
(W) \_\_\_\_\_  
Address \_\_\_\_\_ E-Mail \_\_\_\_\_  
\_\_\_\_\_ Cell Phone \_\_\_\_\_  
\_\_\_\_\_ Pager \_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Business Address \_\_\_\_\_  
Company \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Occupation \_\_\_\_\_  
Spouse Name \_\_\_\_\_ Spouse Telephone \_\_\_\_\_

Person financially responsible for account \_\_\_\_\_  
Relationship \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Driver's License # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## **Primary Dental Insurance**

## **Secondary Dental Insurance**

Insurance Company	_____	Insurance Company	_____
Employee	_____	Employee	_____
Employee SS#	_____	Employee SS#	_____
Employee DOB	_____	Employee DOB	_____
Group #	_____	Group #	_____
Contract #	_____	Contract #	_____

In case of emergency, whom may we contact? \_\_\_\_\_  
Telephone (H) \_\_\_\_\_  
(W) \_\_\_\_\_