MORTENSON® Family Dental

PATIENT REGISTRATION

Patient's Name: ____ Preferred Name: ____ Today's Date: ____

Sex: ☐ M ☐ F Birth Date: ____ Age: ____ SSN: ____

Please check one: ☐ Single ☐ Married

Primary Language: ____ Occupation: ____

Home Address: ____ City: ____ State: ____ Zip: ____

Email Address: ____

Home Phone #: ____ Work Phone #: ____

Cell Phone #: ____ Fax # ____

Your Employer: ____ How Long Employed: ____

Are you a Full Time Student? *If patient is a minor we need:*

☐ Yes ☐ No Mother's DOB: ____ Father's DOB: ____

Person Responsible for Account: ____ SSN #: ____

Email address: ____

Home Phone #: ____ Work Phone #: ____

Cell Phone #: ____ Fax #: ____

Employer: ____

How did you hear about our office? ☐ **Through the Mail** ☐ **Television** ☐ **Radio** ☐ **Community Event**

☐ **Newspaper** ☐ **Billboard** ☐ **Summit Website** ☐ **Social Media** ☐ **Personal Referral**

Name of person referring you to us? ____ **Relationship** ____

EMERGENCY INFORMATION

Name, Address & Phone of a relative not living with you: ____

____

Reason for this visit: ____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: ____

DOB: ____ SSN: ____

Insured's Employer: ____

Insurance Company: ____

Ins. Co. Address: ____

____

Phone # ____

Group # ____ Local # ____

If you have a double insurance coverage, complete this for the second coverageu

Insured's Name: ____

DOB: ____ SSN: ____

Insured's Employer: ____

Insurance Company: ____

Ins Co. Address: ____

____

Phone# ____

Group # ____ Local # ____