

# MAIN | PALMER

FAMILY DENTISTRY *committed to comfortable care*

## Patient Registration

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Martial Status: \_\_\_\_\_

## Insurance Information

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Birthdate: \_\_\_\_\_

Relationship to Insured: (Please check one) Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other: \_\_\_\_\_

How did you hear about our office?

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**Thank You for choosing Main and Palmer Family Dentistry**

**We know you have many choices when it comes to choosing your dental needs.**

**We are so pleased you see the value in choosing our dental practice.**