OAKTON FAMILY
DENTISTRY

PATIENT REGISTRATION

Patient Information. **Please PRINT clearly. Thank you.**

First name: _____Last name: _____Middle Initial: _____
Address: _____
City, State, Zip: _____
Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____
Birth Date: _____ Age: _____ Soc. Sec: _____
Sex: □ Male □ Female Marital Status: □ Married □Single □ Divorced □ Separated □Widowed
Employment Status: □ Full Time □ Part Time □ Retired
Name of Employer:_____ City, State: _____
Student Status: □ Full Time □ Part Time Name of School_____
Email address:_____
Physicians Name:_____Phone:_____
Main Dental concern:_____
Do you use a pre-medication prior to dental treatment (Anti-biotic)? _____
Who referred you to our office? (Referral Source)_____
EMERGENCY CONTACT _____ Phone:(___) ____-_____

Responsible Party (if someone other than patient)

First name: _____Last name: _____Middle Initial: _____
Address:_____
City, State, Zip: _____
Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____
Birth Date:_____ Soc. Sec: _____

□ Responsible party is also the Policy Holder for Patient
□ Primary Insurance Holder
□ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Policy Holder:_____
Policy Holder SSN #_____ Policy Holder Birth Date:_____
Policy Holder **ID #**:_____ Group ID #:_____
Relationship of patient: □ Self □ Spouse □ Child □ Other
Name of Policy Holder's Employer:_____ City, State:_____
Name of Insurance Company:_____
Address:_____ City, State, Zip_____