BURLINGTON FAMILY DENTISTRY

PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name_____

Preferred Name_____

Sex: ☐ Male ☐ Female Birth Date_____ Social Security #_____

Address_____City_____ State_____ Zip_____

Cell #_____Work #_____Home #_____

E-mail_____

Emergency Contact_____ Relation_____ Ph #_____

How did you hear about our office_____

ACCOUNT INFORMATION

Is the patient financially responsible for themselves? ☐ Yes ☐ No

If someone other than the patient will pay for the patient's treatment:

Name of Responsible Party_____

Relation to Patient_____

Responsible Party's Signature_____

Cell #_____Work #_____Home #_____

E-mail_____

Address ☐ Same as Patient OR _____

_____ _____

Signature of Patient or Guardian Today's Date