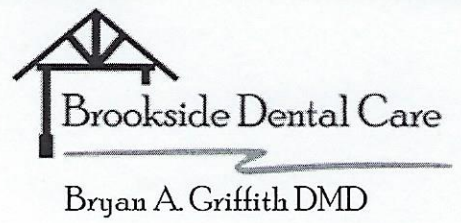


Date _____



Patient Registration

ABOUT YOU

First Name _____ Last Name _____ Middle Initial _____
 I prefer to be called _____ [] Male [] Female
 Address _____
 City _____ State _____ Zip: _____
 Home Phone _____ Work Phone _____ Ext: _____ Cellular _____
 E-mail: _____
Marital Status: [] Married [] Single [] Divorced [] Separated [] Widowed
 Birth Date: _____ Age _____ Soc Sec: _____
 Employer _____ Occupation _____
 Emergency Contact: _____ Phone # _____
 Physician's name _____ Physician's phone # _____
 Preferred Pharmacy _____ Pharmacy Phone # _____

PERSON RESPONSIBLE FOR ACCOUNT

[] Same as above
 Name: _____ D.O.B. _____ Relation: _____
 Billing Address: _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Ext: _____
 Employer _____ Occupation _____ S.S. # _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name _____ Phone() _____
 Group/Policy # : _____
 Insured's Name _____ Insured's Birth Date __/__/__ Relation _____
 Insured's Soc Sec #: _____ Insured's Employer _____

Secondary Insurance

Insurance Co. Name _____ Phone() _____
 Group/Policy # : _____
 Insured's Name _____ Insured's Birth Date __/__/__ Relation _____
 Insured's Soc Sec #: _____ Insured's Employer _____

Please tell us how you heard about Dr. Griffith. Please check all that apply.

() Another patient- Name _____ () T.V. Commercial
 () Radio () Referral Card () Website () Family/Friend _____
 () Other _____