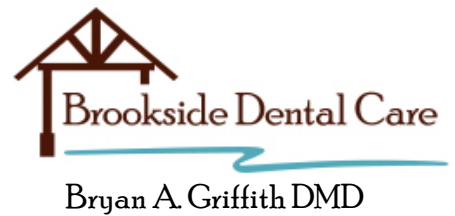


Date _____



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 _____

If you would like to give us permission to discuss information about you (treatment, appointments, dental conditions, financials, etc.) with someone else, please check this box.

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 _____