

**PENINSULA**  
Periodontics & Orthodontics



**REGISTRATION FORM**

<b>Section I:</b>	<b>Patient Information</b>	<b>Date</b> _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
How long @ above address: _____ Date of Birth: _____ Social Security Number: _____		
If less than 3 years: Previous Address: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____ Length of Employment _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Section II</b>	<b>Responsible Party</b>
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Patient: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Section III</b>	<b>Insurance Information</b>
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Length of Employment: _____ Work Phone: (____) _____	
Name of Employer: _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING -----	
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State: _____ Zip _____	
Insurance Company _____ Grp # _____ ID# _____	
Ins Co Address: _____ Ins Co. Phone: _____	

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initials) \_\_\_\_\_