

RACINE DENTAL GROUP, S.C.

1320 S. Green Bay Road • Racine, WI 53406 • 637-9371

PATIENT REGISTRATION FORM

PATIENT INFORMATION

LEGAL NAME _____ MALE FEMALE S.S. # _____
ADDRESS _____ APT. _____ BIRTH DATE ____ / ____ / ____
CITY _____ STATE _____ ZIP _____ PHONE (____) _____
IF PATIENT IS A MINOR: NAME OF MOTHER _____
NAME OF FATHER _____
MINOR RESIDES WITH: MOTHER FATHER BOTH OTHER _____
PERSON TO NOTIFY IN CASE OF EMERGENCY _____
(other than residence)
RELATIONSHIP _____ PHONE (____) _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT: _____ BIRTH DATE ____ / ____ / ____ S.S. # _____
LEGAL NAME _____ RELATIONSHIP _____
ADDRESS _____ APT. _____
CITY _____ STATE _____ ZIP _____ PHONE (____) _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ PHONE (____) _____
SPOUSE NAME _____ BIRTH DATE ____ / ____ / ____ S.S. # _____
ADDRESS (if different) _____ APT. _____
CITY _____ STATE _____ ZIP _____ PHONE (____) _____
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ PHONE (____) _____

DENTAL INSURANCE INFORMATION

INSURED NAME _____ S.S. # _____ BIRTH DATE ____ / ____ / ____
PRIMARY INSURANCE COMPANY _____ PHONE (____) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ EFFECTIVE DATE _____
UNION / LOCAL # _____ GROUP # _____ MEMBER # _____
SECONDARY INSURANCE COMPANY _____ PHONE (____) _____
INSURED NAME _____ S.S. # _____ BIRTH DATE ____ / ____ / ____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ EFFECTIVE DATE _____
UNION / LOCAL # _____ GROUP # _____ MEMBER # _____

TREATMENT INFORMATION

PURPOSE OF VISIT _____ DATE OF LAST EXAM _____
IS THIS YOUR FIRST VISIT TO OUR OFFICE? YES NO PREVIOUS DENTIST _____
OTHER FAMILY MEMBERS SEEN BY US _____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____