FOUNTAIN LAKE
FAMILY DENTAL

PATIENT REGISTRATION FORM

Responsible Party **(for anyone who is a minor, has a Power Of Attorney, and/or is the insurance policy holder)**

First & Last Name: _____ Middle Initial: ____ DOB:_____

Address: _____City, State, Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____

Social Security Number: _____

Email:_____

*Primary Insurance: _____ Employer:_____

Subscriber/Member ID #:_____Group/Policy #: _____

*Secondary Insurance (if any):_____Employer:_____

Subscriber/Member ID #:_____Group/Policy #: _____

Patient Information **(if patient is the responsible party, leave blank)**

First & Last Name: _____ Middle Initial: ____ DOB:_____

Address: _____City, State, Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____

Social Security Number: _____

Emergency Contact:_____ Phone number:_____

Relationship to patient:_____