



Ben Daniel DMD, PA
Family and Cosmetic Dentistry

PATIENT REGISTRATION

First name: _____ Last name: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____

Cellular Phone: _____ Email address: _____

How did you hear about our office? _____ Sex: Male ___ Female ___

Marital Status: Married ___ Single ___ Divorced ___ Separated ___ Widowed ___

Spouse's name: _____ Patient birth date: _____

Age: _____ Soc. Sec. #: _____ Hobbies: _____

The patient is: Responsible party ___
Insurance policy holder ___

*Employer of policy holder _____
Insurance company _____

Responsible Party (if other than the patient); if same, do not duplicate:

First name: _____ Last name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work phone: _____

Cellular Phone: _____ Email: _____

Birth date: _____ Soc. Sec. #: _____