# Patient Registration

Date _____

Patient's Full Name: _____
S.S. #: _____ DOB: _____ Age: _____ Circle One: F M
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax #: _____
Email Address: _____ D.L. #: _____
Mailing Address: _____ Apt. #: _____
City _____ State _____ Zip _____

If Child: Mother's Name: : _____ Work #: _____
Father's Name: _____ Work #: _____

**Employment:** (if minor, responsible parties)
Employed By: _____
Position: _____ May we call you at work? _____
Address: _____

**Marital Status:**
Circle One: Married Single Separated Divorced Widowed

Spouse's Name: _____ S.S. #: _____
Spouse's Employeer: _____ Phone #: _____
Address: _____

**In case of emergency:**
Name: _____
Relationship: _____ Phone#: _____
Second Contact: _____
Relationship: _____ Phone#: _____

**Insurance Information**

**Primary**
Insured: _____ S.S.# _____
Name of Insurance Co. _____ Group #: _____
Address: _____ Phone #: _____

**Secondary**
Insured: _____ S.S.# _____
Name of Insurance Co. _____ Group #: _____
Address: _____ Phone #: _____

To the extent permitted under applicable law, I authorize the release of any information needed in relation to filing dental claims. I hereby authorize payment of the dental benefit otherwise payable to me directly to Ken Sykes, DDS. I understand that I am financially responsible for all charges. Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, money orders and all major credit cards. I also agree to pay all fees incurred in the recovery of this account. There will be a minimum charge of $35 for No Show appointments or Less than 1 Business day prior notice of cancellation or reschedule.

Signature: _____ Date: _____

Referred By: _____