Legacy Smile Family Dental

Patient Registration Form
(Confidential)

Today's date: _____

We welcome you to our practice! Thank you for selecting our dental office. Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Patient Name _____
First Middle Last

Birth date _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other
(MM / DD / YYYY)
Social Security# _____ Driver's License# _____

Home Address: _____Apt#_____

City: _____State: _____Zip: _____

Home Phone: _____ Cellular:_____

Email: _____
(We will not sell or share your information)
Emergency Contact Name: _____ Phone:_____

Patient Employer/School _____Occupation_____

Employer/School Address _____ Employer/School Phone _____

Choose clinic because/referred to clinic by (please check one box):

☐ Insurance Plan ☐ Office Sign ☐ Google ☐ Website
Family members seen here ☐ Yes ☐ No Who? _____
Referred by:_____

RESPONSIBLE PARTY

First Name: _____ Last Name: _____Middle Initial: _____

D.O.B: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other

SSN# _____ Driver's License # _____

Email: _____

Relationship to Patient: _____