RiverTree
Dental

Patient Registration

Patient Name: ____
First (Preferred) MI Last

Mailing Address: ____
Street City State Zip

Home Phone: ____________________ **Cell Phone:** ____________________

Date of Birth: ____________________ **SS#:** ____________________

Email: ____________________ **Sex:** M F **Marital Status:** ____________

Emergency Contact: ____________________ **Phone:** ____________________

How did you hear about our office? ________________________________

Responsible Party Name: ____
(If different then above) First MI Last

Dental Insurance (Primary): ____
(If applicable)
Subscribers Name: ____
First MI Last

Subscribers Date of Birth: ______________ **Subscribers SS#:** ______________

Subscriber ID#: ______________ **Subscribers Employer:** ______________

Dental Insurance (Secondary): ____
(If applicable)
Subscribers Name: ____
First MI Last

Subscribers Date of Birth: ______________ **Subscribers SS #:** ______________

Subscriber ID #: ______________ **Subscribers Employer:** ______________

Signature: ________________________________ **Date:** ______________