# STEVEN D. STRICKLAND, D.D.S., P.C.

## PATIENT REGISTRATION

***PATIENT INFORMATION***

**PATIENT'S NAME:**

**Last_____First_____M.I._____**

**SEX: M F BIRTHDATE:_____ SSN:_____**

**MAILING ADDRESS:**

**Street_____City_____State____Zip_____**

**PHONE NUMBER(s) Home:_____Work:_____Cell:_____**

**Email: _____**

**HOW WOULD YOU LIKE US TO CONTACT YOU TO CONFIRM YOUR APPOINTMENTS? Home / Work / Cell**

**Whom May We Thank For Referring You to Our Office?**

**_____**

**REASON FOR VISIT: _____**

**EMERGENCY CONTACT – who do we contact in case of an emergency?:**

**NAME: Last_____First_____M.I._____**

**ADDRESS: Street_____City_____State_____Zip_____**

**PHONE NUMBER(s) Home:_____Work:_____Cell:_____**

**Relationship to You:_____**

***DENTAL INSURANCE INFORMATION*** **(Primary Carrier)**

**Insured's Name: Last_____First_____MI_____**

**Birthdate_____ Insurance Co._____**

**Co._____Phone_____**

**Insured's Employer:_____SSN #_____**

**Group_____ Employers ID #_____**

**PATIENT SIGNATURE (Parent if child)**

**_____Date_____**