Masterpiece Family & Cosmetic Dentistry

Adult Patient Registration

The following information is for our records only and will be considered confidential.

Name_____ Preferred Name_____
Last First Middle Initial

Address_____City_____ State____ Zip_____

Birthdate_____ SSN_____ TDL_____
Please provide photo ID

Home Phone_____ Cell Phone_____

E-Mail Address_____ Would you "like" us on Facebook? Y N

Refer us a new patient and you may win the lottery!

How may we best contact you? (Circle all that apply) Home Phone Answering Machine Cell Phone Voice Mail Work Phone E-Mail Text Message

Are any immediate family members current patients of record? Yes_____ No_____

If so, Name_____ Relationship to patient_____

Person Responsible for Account_____ Phone_____

Address_____ City_____ State____ Zip_____

Who may we contact in case of emergency (other than spouse)?_____

Relationship to Patient_____ Phone_____

Present Employer_____ Phone_____ Ext_____

May we contact you at work for appointment reminders or schedule changes? Yes No

If Married, Spouses Name_____ Birthdate_____

Spouses Employer_____ Phone_____ Ext_____

Spouse's SSN (for insurance purposes)_____

Spare Time Activities or Hobbies_____

Special Interests_____

Who may we thank for referring you to this office?_____

I will be paying by: Cash_____ Check_____ Credit Card_____ Debit Card _____

Care Credit_____ Lending Club_____ Wells Fargo _____ Other (list)_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, including Adjunctive Comprehensive Services. (List available upon request). I have reviewed all of the above information and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes of the above information.

Signature_____ Date_____