TENNESSEE RIVER
DENTAL

Patient Registration Form

Date: _____/_____/_____

Name: Dr./Mr./Mrs./Ms. _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Home phone: (_____)_____-_____ Work phone: (_____)_____-_____

Cell phone: (_____)_____-_____ Email: _____

Employer:_____ Occupation:_____

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____

Referral Information

How did you hear about our office? _____

Is another family member or relative a patient in our office? Yes ☐ No ☐

Emergency Contact

Name:_____ Relationship to patient:_____

Address: _____ Phone: (_____)_____-_____

Person Financially Responsible for Account

Name: _____ Relationship to patient: _____

Address: _____ Phone: (_____)_____-_____

Do you have dental benefits? Yes☐ No☐ *If yes, provide cards to be copied.*

Primary Ins. Co._____ Secondary Ins. Co._____

Subscriber ID#: _____ Subscriber ID #: _____

Employer: _____ Employer: _____

Employee's Name: _____ Employee's Name: _____

Employee's DOB: _____/_____/_____ Employee's DOB: _____/_____/_____