# *REGISTRATION FORM*

## *for*

## *THE DENTIST'S HOUSE OF EDINA*

*"a comfortable approach to dentistry"*

***PLEASE have fill out by THE RESPONSIBLE PARTY***

***(This individual must be over the age of 18 and if required, be a parent and/or guardian)***

## *Patient Information:*

*Patient's Name*_____*Sex*_____*Birthdate*_____*Soc. Sec. #* _____
*(only if insurance filing)*

*Home Address*_____*City*_____*State*_____*Zip*_____

*Email* _____ *May we contact you: ( )phone ( )text ( )email ( ) leave a message?*

*Daytime/Cell Phone Number (_____)* _____ *Home Phone Number (_____)* _____

*Patient's Employer Name*_____ *Employer's Phone Number (_____)* _____
*(we will not call)*

*Employer's Address*_____*City*_____*State*_____*Zip*_____

## *Responsible Party (only complete if different than patient) or Power of Attorney:*

*Name*_____*Sex*_____*Birthdate*_____*Soc. Sec. #* _____
*(only if insurance filing)*

*Home Address*_____*City*_____*State*_____*Zip*_____

*Email* _____ *May we contact you: ( )phone ( )text ( )email ( ) leave a message?*

*Daytime/Cell Phone Number (_____)* _____ *Home Phone Number (_____)* _____

*Employer Name*_____ *Employer's Phone Number (_____)* _____
*(we will not call)*

*Employer's Address*_____*City*_____*State*_____*Zip*_____

## *Dental Insurance Information: (if applicable)*

*Who has the Dental Insurance? (Please check one)* _____*Patient* _____*Responsible Party* _____*if someone else, please provide:*

*Insured Name*_____*Sex*_____*Birthdate*_____*Soc. Sec. #* _____

*Home Address*_____*City*_____*State*_____*Zip*_____

*Email* _____ *May we contact you: ( )phone ( )text ( )email ( ) leave a message?*

*Daytime/Cell Phone Number (_____)* _____ *Home Phone Number (_____)* _____

*Employer Name*_____ *Employer's Phone Number (_____)* _____
*(we will not call)*

*Employer's Address*_____*City*_____*State*_____*Zip*_____

*Please provide your insurance card(s) for us to make a copy.*

*Primary Dental Insurance Company's Name*_____

*If applicable- Secondary Dental Insurance Company's Name*_____*(please fill out Secondary Insurance Information Form)*

*Thank you!*