Dakota Family Dentistry
Registration Form

Patient Information

First Name:	Last Name:	Middle Initial:
Date of Birth: Age:	Sex: ○ Male ○ Female	
Social Security #:	Address:	
Phone #:	Cell #:	
If Child: Parent/Guardian Name:	If Child: Parent/Guardian Social Security #:	
E-mail Address:		
Occupation:	Employer:	
Employer Address:	Employer Phone #:	
Spouse Name:	Spouse Social Security #:	
Spouse Employed By:	Employer Phone #:	
Who is Responsible for this account:	Method of Payment : (Circle One) Insurance Cash Credit card	
Other Family Members in this Practice:	Who may we thank for this referral:	

In Case of Emergency

Name of relative or friend (Not living at the same address):	Relationship to patient:
Phone #:	Cell #:

Insurance:

*Please bring insurance card and photo ID to your appointment