PATIENT REGISTRATION FORM

Poulsbo 360.697.3008 | Mailing: P.O. Box 2257, Poulsbo, WA 98370 | Office: 18825 Caldart Ave. NE, Suite A
Bainbridge 206.842.0337 | Mailing: P.O. Box 2257, Poulsbo, WA 98370 | Office: 727 Ericksen Avenue NE, Suite 1
www.linkorthodontics.com

Today's Date

_____

PATIENT'S INFORMATION

Name _____ Middle Initial _____

Nickname _____

Phone Number _____ E-mail _____

Birthday _____ Gender _____ Age _____

Patient's Dentist _____

Marital Status: Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]

RESPONSIBLE PARTY (Main contact person for scheduling, billing and mailing address for correspondence)

Name _____ Relationship to Patient _____

Phone Numbers H _____ W _____ C _____

Email _____ Birthday _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Employer _____ Occupation _____

How may we contact you? Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Text Message [ ]

ALTERNATE CONTACT

Name _____ Relationship to Patient _____

Phone Numbers H _____ W _____ C _____

Email _____ Birthday _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Employer _____ Occupation _____

PRIMARY DENTAL INSURANCE

Name of Insurance _____

Name of Subscriber _____ Group # _____ Insured's DOB _____

If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Phone # _____

SECONDARY DENTAL INSURANCE

Name of Insurance _____

Name of Subscriber _____ Group # _____ Insured's DOB _____

If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Phone # _____

HOW DID YOU FIND US?

Whom may we thank for referring you? Another Dentist or Doctor [ ] _____

Insurance [ ] _____ Family/Friend [ ] _____ Other [ ] _____