Michael J. Nelson, D.D.S.
Small town dentistry in a big city

PATIENT REGISTRATION FORM

Today's Date_____

PATIENT REGISTRATION

Patient Name	Preferred Name	Birthdate	Sex M F
Address	City	State	Zip
Student Status FT PT	School	Location	
Home Phone ( )	Cell Phone ( )	Work Phone ( )	
Employer	Business Address	E-mail	
Soc. Sec. No.		Marital Status: S M D W	
Spouse's Name	Spouse's Soc. Sec. No.		
Spouse's Employer	Referred By		
Emergency Contact Name	Relationship	Phone	

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name	Relationship to Patient
Street Address	Phone
Employer	Soc. Sec. No.
Business Address	Phone

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Business Address		
Insurance Company			Group No.
Insurance Company Address			
Patient's Relation to Subscriber: Self Spouse Dependent		Have You Used Your Dental Insurance This Benefit Year? Yes No	
Are You Covered Under More Than One Dental Plan? Yes No		If Yes, Please Fill Out Next Section	

SECONDARY INSURANCE

Subscriber's Name	Employee I.D. #	Birthdate	Soc. Sec. No.
Employer	Group No.	Insurance Co.	Relationship to Patient
Insurance Company Address			

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party_____ Date_____