Engle Dentistry
Registration

Today's Date: _____/ _____/ _____ **Chart #: _____**

Name: _____
Last First Initial

SSN: _____- _____- _____ **Date of Birth: _____/ _____ /_____** **Email: _____**

Local Address: _____
Street City State/Zip

Other Address: _____
Street City State/Zip

Home Phone: _____ **Cell Phone: _____**

Occupation: _____ **Employment: _____** **Work Phone: _____**

Sex: _____ **Marital Status: _____** **Driver's License: _____**
State Number

Referred by: Patient - _____ **Doctor- _____** **Ad- _____** **Other- _____**

Is anyone from your family a current patient of Engle Dentistry? Yes OR No If yes, who? _____

In Case of Emergency Call: _____ **Phone #: _____**

Do you have Dental Insurance? Yes OR No Insurance Company Name: _____

Policy Holder: Self _____ Spouse _____ Other (Specify) _____ **Spouse/Other Name: _____**

Phone #: _____ **SSN: _____-_____-_____** **Policy Holder Date of Birth: _____ / _____ / _____**

Insurance Co. Address: _____
Street City State/Zip

Group Plan: _____ **Group #: _____** **Member/Sub ID #: _____**

Previous Dentist: _____ **City: _____**

Phone #: _____ **Date Last Seen: _____**