Strobel Family Dentistry

Registration

(PLEASE PRINT) Date ___/___/_____

Patient's Name — Last	First	Middle	Sex	Date of Birth

Social Security Number	Home Phone	Work Phone	Cell Phone	Email

Address — Street	(Apt. #)	City	State	Zip

Marital Status (Check One) ☐ M ☐ S ☐ D ☐ W ☐ UNDER AGE 18	Spouse's Name (If Married) / Guardian's Name(s) (If Under Age 18)

Patient's/Guardian's Employer — Occupation	(If Married) Spouse's Employer — Occupation

Work Address — Street	City	State	Zip

(If Married) Spouse's Work Phone Number	Spouse's Social Security #	Spouse's Date of Birth

In Case of Emergency Contact — Name	Relationship	Phone Number

INSURANCE AND FINANCIAL INFORMATION

Insurance Coverage (Check One) ☐ YES ☐ NO	(If "Yes") Insurance Company Name

Subscriber's Name	Patient's Relationship to Subscriber ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Subscriber's Date of Birth	Subscriber's Social Security #

Group Number	Employer (If Different from Previous Statement)