PATIENT REGISTRATION

TODAY'S DATE_____ **Mayo Clinic # _____**

Patient Name _____ Sex ☐ Male ☐ Female Age ____ Birthdate _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Home Phone _____

Please select one: ☐ Married ☐ Single Social Security Number _____ Work Phone _____

Driver's License Number _____ Cell Phone _____

If student, name of school _____

If a new patient, how did you hear of our office? _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Wife's name or (mother's name if patient is a minor) _____Birthdate _____

Home Phone _____ Cell Phone _____ SS # _____

Address _____City_____ State _____Zip_____

Employed by _____ Work Phone _____

Husband's name or (father's name if patient is a minor) _____ Birthdate _____

Home Phone _____ Cell Phone _____ SS # _____

Address _____City_____ State _____Zip_____

Employed by _____ Work Phone _____

Name of nearest friend or relative (not at the same address) in case of emergency:

Name _____Phone_____

Address_____City_____State_____Zip_____

Dental Insurance

If you have dental insurance, it is important that you bring a copy of your insurance card with you to your appointment.