



31 Lowell Road  
Windham, NH 03087  
603 898 2072

**PATIENT REGISTRATION FORM**

**Welcome to our practice!**

Thank you for selecting our office for your dental care. Please fill out this form completely in ink and print clearly. If you have any questions or concerns, please ask for assistance - we will be happy to help.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS.# \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Are you: Minor Single Married Divorced Widowed Separated

You or your parent's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If you are a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

**We appreciate patient's referring others to us. Who may we thank for referring you?** \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person responsible for this account \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

What is the **purpose** of today's visit? \_\_\_\_\_

Signed \_\_\_\_\_ Guardian if Minor \_\_\_\_\_ Date \_\_\_\_\_