

# PATIENT REGISTRATION



IF THIS APPOINTMENT IS FOR YOU START HERE

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION		
DATE		
LAST NAME	FIRST	M.I.
PREFERS TO BE CALLED BY		
ADDRESS		
CITY	STATE	ZIP
EMPLOYER		WORK PHONE
HOME PHONE		CELL PHONE
BIRTHDATE	AGE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
SOCIAL SECURITY NO.		E-MAIL



IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

PATIENT'S LAST NAME	FIRST	M.I.
PREFERS TO BE CALLED BY		
PATIENT'S ADDRESS		
CITY	STATE	ZIP
PATIENT'S HOME PHONE		PATIENT'S CELL PHONE
PATIENT'S BIRTHDATE		PATIENT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PARENT/GUARDIAN'S LAST NAME	FIRST	M.I.
PARENT/GUARDIAN'S ADDRESS		
CITY	STATE	ZIP
PARENT/GUARDIAN'S HOME PHONE		PARENT/GUARDIAN'S CELL PHONE
PARENT/GUARDIAN'S EMPLOYER		PARENT/GUARDIAN'S WORK PHONE



**Welcome**

Dennis R. Krug D.D.S  
Cottage Dental Care, LLC  
2206 Cottage Avenue  
Bloomington, IL  
61701

GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?    YES    NO	
NAME	RELATIONSHIP
YOU WERE REFERRED TO US BY	
EMERGENCY CONTACT NAME	PHONE NUMBER
ADDRESS	CITY    STATE    ZIP
CLOSEST RELATIVE NAME (NOT LIVING WITH YOU)	RELATIONSHIP
ADDRESS	PHONE NUMBER
CITY	STATE    ZIP