



# Silverdale Dental Center

3637 NW BYRON STREET • SILVERDALE, WASHINGTON 98383 • (360) 692-9560

Welcome to our office! In order for us to provide you with our best and most appropriate dental care in a safe and comfortable manner, it is important that we get to know you and the details about your previous medical and dental experiences. Please answer the following questions as accurately, honestly and completely as possible. All information will be held in professional confidence.

## Dr. Phillips and Staff

### PATIENT REGISTRATION

(PLEASE PRINT CLEARLY)

DATE \_\_\_\_\_

Patients Name \_\_\_\_\_ Name you prefer to be called \_\_\_\_\_  
LAST FIRST MIDDLE

Home Address \_\_\_\_\_  
# & STREET CITY STATE ZIP HOME PHONE

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Status:  Minor (under 18 years of age)  Single  Married  Divorced  Widowed

If Child, Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
LAST FIRST MIDDLE

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
LAST FIRST MIDDLE

Name of Spouse \_\_\_\_\_ Social Security # \_\_\_\_\_  
LAST FIRST MIDDLE

Children in Family (names & ages) \_\_\_\_\_

Have you ever been a patient of ours?  Yes  No Has any member of your family ever been a patient of ours?  Yes  No

Occupation (or school) \_\_\_\_\_ (grade) \_\_\_\_\_

Patient/Parent Employed by \_\_\_\_\_ How Long? \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ How Long? \_\_\_\_\_

Spouse's Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Person Financially Responsible for Account \_\_\_\_\_  
(NOT INSURANCE COMPANY) FULL NAME DRIVERS LICENCE # HOME PHONE

Billing Address \_\_\_\_\_  
# & STREET CITY STATE ZIP

Employed by \_\_\_\_\_  
BUSINESS OR COMPANY POSITION HELD HOW LONG? WORK PHONE

Who may we thank for referring you to our office? \_\_\_\_\_

Should we have a change in schedule, would you like to be called to take an appointment with short notice to expedite your treatment?  YES  NO

### IN CASE OF AN EMERGENCY CONTACT

Nearest friend or relative \_\_\_\_\_  
(not living with you) FULL NAME RELATIONSHIP WORK PHONE HOME PHONE

Address \_\_\_\_\_  
# & STREET CITY STATE ZIP

### DENTAL INSURANCE INFORMATION

FIRST COVERAGE

SECOND COVERAGE

Employee Name \_\_\_\_\_ Employee Name \_\_\_\_\_

Employee Date of Birth \_\_\_\_\_ Employee Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ # Years \_\_\_\_\_ Employer \_\_\_\_\_ # Years \_\_\_\_\_

Name of Ins. Co. \_\_\_\_\_ Name of Ins. Co. \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Policy # \_\_\_\_\_

Employee Social Security # \_\_\_\_\_ Employee Social Security # \_\_\_\_\_