New Patient Registration Form

Market Street Dental

Paul L. Boger, DMD ◦ Raymond J. Johnson, DMD

Welcome and thank you for choosing Market Street Dental to meet your dental needs.

Today's Date _____ May we ask how you heard of us?_____

Patient Information

_____

First Last MI DOB SS#

_____

Address City State Zip Code

(___)_____(___)_____(___)_____ _____

Home Phone Cell Phone Work Phone Email address

May we text you to confirm your appointments? Yes_____ No_____

_____ _____

Emergency Contact Relationship Phone

Are you required to pre-medicate (ie take an antibiotic) prior to dental treatment? Yes____ No____

Financial Responsibility for account

_____

Responsible Party's Name SS# Relationship to Patient

_____

Mailing Address Phone

Signature_____

Responsibility for dental/medical decision-making

If the patient is a minor or otherwise unable to make medical/dental decisions for him or herself, please indicate the person(s) who is (are) legally responsible for making medical and dental decisions on his or her behalf.

Name(s)_____ Relationship(s) to patient_____

Address & Phone # (if different from above):_____

_____

Signature(s): _____