5760 State Hwy 121, Suite 230
Plano, Texas 75024

Waterstone DENTAL

Office: 972-377-0800
Fax: 972-377-0838

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ Middle Initial: ____

Preference Name: _____

If Patient is a Minor, give Parent's or Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: M / F Marital Status: O Married O Single O Divorced O Separated O Widowed

Date of Birth: _____ Social Security #: _____ Driver's Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Employer: _____ Occupation: _____ No.of Years Employed: ____

Emergency Contact Name/Address/Phone No. _____

_____

Responsible Party Information (if someone other than the patient)

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Date of Birth: _____ Social Security #: _____ Driver's Lic: _____

Relationship to Patient: _____

Primary Insurance Information

Name of Insured: _____ Relationship_____

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip _____

Insurance Company Name:_____ Address: _____

City: _____ State: _____ Zip _____

How did you hear about us? Please check below:

O Yellow Pages O Sign O Employee O Friend / Relative O Mail Coupon

O Bill Board O Employer O Magazine – Which one? _____

O News Paper – Which one? _____ O Other (specify) _____