



Family & Cosmetic Dentistry

Raymond Ferri, D.D.S., & Patrick Lawrence, D.D.S., P.A.

Patient Registration

Basic Contact Information

Last Name	First Name
Middle Initial	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth:	Age:
Social Security Number	If patient is a Minor, give Parent or Guardian's Name
Today's Date	
Have any of your family members been seen in our office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please list family member name(s)	
How did you hear about our office?	
Reason for visit?	

Responsible Party Information

Last name	First name
Middle Initial:	Marital Status:
Mailing Address	
Apt #	City
State	Zip
Home Phone	Work Phone
Ext.	
Cell Phone:	E-mail Address
Driver License #:	
State:	
Preferred method of contact: <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Text <input type="checkbox"/> Email	
Social Security #:	DOB:
Relationship to Patient:	
Employer:	
Occupation:	No. of years employed:
Mailing Address:	State:
Zip code	

Responsible Party Spouse

Last name	First name
Middle Initial	
Home Phone	
Work phone	Ext:
Cell Phone:	Driver License #:
State:	Social Security #:
DOB:	Employer
Occupation	
No. of years employed:	
Mailing Address:	
State:	Zip code

Dental Insurance Information

Primary Carrier Insured's Name:	Insured's Employer
Insured's Social Security #	
Insurance Company	
Group #:	
Phone Number	
I have filled out this form to the best of my knowledge: <input type="checkbox"/>	
Signature of patient, parent or guardian:	Date:
Relationship to patient:	