Malinoski & Associates, D.D.S., P.C.
717 Health Parkway
Three Rivers, MI 49093
(269) 279-7876

File#_____

Date:_____

Confidential Patient Registration

In order to help us render the proper dental services to you, please answer the following questions. Please note the space for remarks for any question that requires clarification or any other information you think we should know. Thank you for your cooperation.

NAME:_____ SS NO:_____-_____-_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____ OTHER PHONE:_____

EMPLOYER:_____OCCUPATION_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

E-MAIL ADDRESS: _____

BIRTHDATE:_____/_____/_____ AGE:_____ SEX: M F

MARITAL STATUS: _____Married _____ Single _____Divorced _____Widowed

SPOUSE
NAME:_____

BIRTHDATE: _____/_____/_____ SS NO: _____-_____-_____

In case of emergency:

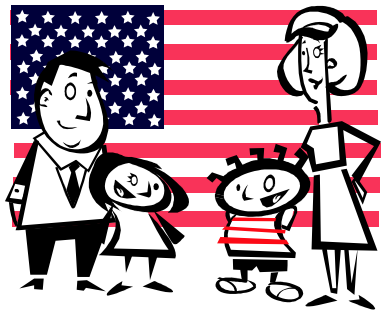
NOTIFY:_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

PHONE: ( )_____-_____

RELATIONSHIP:_____



How did you hear of our office?_____

DENTAL INSURANCE: I am insured by the following dental plans:

	1	2	3
Subscriber			
Birthdate			
SS#			
Insurance Co.			
Group #			
Employer			
Relationship			

***ALL MINORS MUST HAVE A PARENT PRESENT
WITH THEM AT EACH VISIT***

17 OR YOUNGER OR GUARDIANSHIP

SUPPORT INFORMATION:
If patient is 17 years or younger or under guardianship, fill in the following.

PARENT / GUARDIAN:

NAME:_____
BIRTHDAY: _____/_____/_____
SS# _____/_____/_____

EMPLOYER:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____
PHONE:( )_____ -_____

Does the patient live with you? _____YES _____NO
If not, what is your:

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

I understand that responsibility for payment for Dental Services provided for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient, Parent or Responsible Party:_____ Date:_____