



File# _____

Date: _____

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

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: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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

MARITAL STATUS: _____ Married _____ Single _____ Divorced _____ Widowed

SPOUSE

NAME: _____

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

In case of emergency:

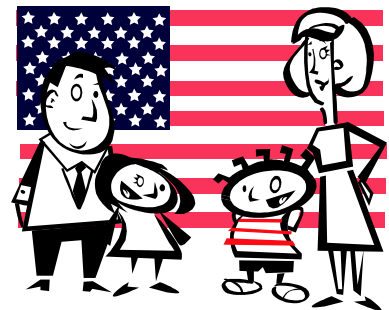
NOTIFY: _____

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: _____