PATIENT REGISTRATION

Kurt C. Rolf, DDS

Patient Information (please print) Date __________

Name ________________________________ Preferred Name _________________ ○ Male ○ Female
Address ____ Home Phone _______________
City/State/Zip ____ Work Phone ________________
Email ____ Cell Phone _________________
Date of Birth ______________ Marital Status ○ Single ○ Married ○ Widowed ○ Divorced
Place of Employment _______________________________________ Soc Sec # __________________
Would you like TEXT or Email reminder ? **Yes** **No**
Whom may we thank for referring you to our office? ____

Dental Insurance Information
Primary Holder ____Employer _______________________
Insurance Company ____________________________________SSN/ SIN# _______________________
Group Number_____________________ DOB _______________INS Company # __________________
Name of Employer________________________

Do you have any additional INSURANCE? Yes NO If yes, complete the following:
Primary Holder ____Employer _______________________
Insurance Company _____________________________________ SSN/ SIN# _______________________
Group Number_____________________ DOB _______________ INS Company # __________________
Name of Employer________________________

Person to Contact in Case of Emergency
Name ____Relationship __________________
Address ____ Home Phone _________________
City/State/Zip ____ Work Phone _________________

Authorization

I hereby authorize Kurt C. Rolf DDS PC to administer such medications and perform such diagnostic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are correct to the best of my knowledge.

SIGNATURE ____ **DATE** ________________