LSU FACULTY DENTAL PRACTICE

PATIENT REGISTRATION

Date: _____________

First Name: ______________________________ Middle Initial: _______ Last Name: _________________________________

Address: _____________________________________ City: __________________________ State: _______ Zip: ____________

Telephone: Home: (_____) __________________ Work: (_____) __________________ Other: (_____) ________________

Sex: ___ Male ___ Female Date of Birth: __________ Age: ____

Social Security #: ___________________________

Did a doctor refer you to the practice? Who? ____________________________ Telephone: (____) _____________________

Marital Status: _______________________________________ Employer: ____

Emergency Contact Name: _____________________________ Phone Number: ______________________________________

Primary Physician: ____________________________________ Telephone: (_____) ___________________________________

Has a member of your family been seen in our practice? Who? ____

I certify that the information on this form is correct, and I understand that I am responsible for any balance on this account.

Signature of Patient or Responsible Party: ____