Veronica M. Enriquez, D.D.S.

WELCOME
WE'D LIKE TO KNOW YOU BETTER. THESE FILES ARE CONFIDENTIAL.

ADULT REGISTRATION INFORMATION

Patient Information

Date: ____________Name ____
Last First MI

Sex: ☐ M ☐ F

Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Long Term Partner

Date of Birth: _____ /______ /_______ Soc. Sec. # _______ - ________ -______________

Address ____

City _________________________________ State _______________ Zip ___________________

E-Mail Address ____

Home Phone _________________ Cell Phone _______________ Work Phone ____________________

In emergency, contact:
Name __________________________ Phone _________________ Relationship ____________________

PRIMARY DENTAL INSURACE

Dental Coverage? ☐ **Yes** ☐ **No**

Insurance Company Name: ____

Insurance Company Address: ____

____
City State Zip

Insurance Co. Phone # (_____) ______________________________________

Insured's ID #: ______________________________ Group #, Plan # or Policy #:________________

Insured's Name: ____________________________ Relation: _________________________________

Insured's Birthdate: _____ /______ /_______

Insured's Employer: ____________________________________ Occupation: ____________________

Employer's Address ____

____
City State Zip

Who should we thank for referring you? ____

Last Dental Visit: Date _________________ Reason: ____________________________________

Purpose of today's visit: ____

I hereby understand and grant authority to administer any treatment or anesthetics and to perform such operations of procedures maybe deemed necessary or advisable in my diagnosis and treatment. Registration and medical and dental questions have been understood and answered to the best of my ability and knowledge. I further accept the financial obligations of my or my dependent's treatment.

Sign (Parent/Guardians if minor) ________________________ Date _______________________