

PATIENT REGISTRATION
Puyallup Valley Dental Care

Date _____ Referred By _____

Name _____ M _ F _ Birth date _____ SSN # _____

Address _____ Email _____

City _____ Zip Code _____

Home Phone _____ Daytime # _____ Cell# _____

Parent/Guardian _____ Spouse/ Other _____

Person responsible for bill:

Name _____ Birth date _____ Social Security # _____

Employer _____ Work Phone _____

Work Address _____

Nearest relative not living with you:

Name _____ Relationship _____

Address _____

Phone _____

Name of person not living with you to be notified in case of an emergency:

Name _____

Address _____

Phone _____

Primary Dental Insurance _____

Insured's Name: _____ Birth date _____

Employer _____ Work Phone _____

Insured's Social Security # _____ Group # _____

Secondary Dental Insurance _____

Insured's Name _____ Birth date _____

Employer _____ Work Phone _____

Insured's Social Security # _____ Group # _____

Signature gives us authorization to submit your insurance and receive payment directly. Patient
Signature OR (Parent/Guardian if patient is under age 18)