Stone Creek
DENTAL CARE

PATIENT REGISTRATION

First Name_____Last Name_____MI_____

Address_____

City, State, Zip_____

Home Phone_____Work Phone_____

Cell Phone_____

Emergency Contact Name_____ Number_____

Relationship_____

(If your number or address changes PLEASE notify us as soon as possible)

Email_____

Birth Date_____Social Security_____

Insurance Information

If you have a Provider One services card, please list the I D number _____

Name of Insurance Company _____

Employer Name and Address_____

Insurance I D number_____

Insurance Group number_____

Insurance Address_____

NO SHOW / CANCEL SHORT NOTICE

Initial_____ Failure to cancel your appointment within 24 hours may result in a $50 fee.

Initial_____ Failure to show up to your appointment may result in a $50 fee.

Initial_____ 2 failed appointments will result in a dismissal from our office.