



**DR. YU & ASSOCIATES**  
PRACTICING THE FINE ART OF PERIODONTICS & IMPLANTOLOGY

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## PATIENT REGISTRATION

### Patient Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Drivers License: \_\_\_\_\_

E-mail Address \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single  Other

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

Referring Dentist Name: \_\_\_\_\_

Physician's Name & Phone #: \_\_\_\_\_

### Preferred Pharmacy:

Name: \_\_\_\_\_ Location (intersection): \_\_\_\_\_

### Responsible Party: (if different than patient)

Relationship to Patient:  Spouse  Parent  Other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### Dental Insurance Information:

Insurance Company Name: \_\_\_\_\_ Ins. Phone Number: \_\_\_\_\_

Ins. Company Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_\_

Policy Holder Soc. Sec. # or Member ID: \_\_\_\_\_