GLEN R. KREITZBERG, D.D.S., P.C.
DUSTIN H. KREITZBERG D.D.S.

PATIENT REGISTRATION

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointment or fees, please feel free to ask. We try to do everything possible to care for your periodontal health. This Acquaintance form will help us to serve you better. All information will be kept confidential.

Patient's Name:			E-Mail Address:		
Preferred Name:			❑ Mr. ❑ Ms. ❑ Mrs. Other ____	Marital status ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widow	
Home phone no.:	Work phone no.:	Cell phone no.:	Birth date:	Age:	Sex: ❑ M ❑ F
Street Address:		Apt no.:	City:	Zip Code:	
Soc. Sec no.:	Employer's Name and Address:			Occupation:	
Other family members seen here:		Whom may we thank for referring you?			

PERSON RESPONSIBLE FOR THIS ACCOUNT			
Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent or Guardian			
Name:	Birth date:	Sex: ❑ M ❑ F	Soc. Sec no.:
Title: ❑ Mr. ❑ Mrs. ❑ Ms. Other _____	Does This Person and Patient Reside in the Same Household? ❑ Yes ❑ No		
Street Address:	Apt no.:	City:	Zip Code:
Work Phone no.:	Home Phone no.:	Cell Phone no.:	
Employer's Name and Address:			Occupation:

IS PATIENT COVERED BY DENTAL INSURANCE ❑ YES ❑ NO					
Insured's Name:	Soc. Sec no.:	Birth date:	Sex: ❑ M ❑ F	Group no.:	Policy no.:
Employer's Name and Address:					
Insurance Company Name:			Address:		
Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent or Guardian					
Name of **secondary insurance** (if applicable):	Insured's name:			Group no.:	Policy no.:
Employer's Name and Address:					
Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent or Guardian					

GUARANTEE OF ACCOUNT

I guarantee full payment of all dental charges incurred by the above patient. I give my consent to needed dental services recommended for my (or any dependents) benefit and accept full responsibility of payment for services performed. I understand the above information and affirm this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Patient/Guardian signature *Date*