Island View Dental
Dr. Rick Kearns
Dr. Matthew Serbousek
Dr. Riley Santin

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PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Cell Phone: _____ Email: _____
Birth date: _____ Social Security #: _____

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Widowed
Best way to confirm appointments: O Call home phone O Call cell phone O Text O Email

Responsible Party (if other than patient):
First Name: _____ Last Name:_____ Middle Initial:____
Birth Date: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Address: _____ City, State, Zip: _____

Emergency Contact Name: _____ Relationship to Patient: _____
Emergency Contact Phone #: _____

REFERRAL SOURCE

How did you learn about our office? O Google O Phonebook O Insurance Company O Website
O Newspaper O Radio O Care to share card-who can we thank? Name: _____

MINOR CHILD INFORMATION

Mother's Name: First Name: _____ Last Name:_____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Address: _____ City, State, Zip:_____

Father's Name: First Name: _____ Last Name: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Address: _____ City, State, Zip: _____

If patient is a college student: O full time O part time School name: _____ City, State:_____

DENTAL INSURANCE INFORMATION

Primary Insurance: Company Name: _____
Policy Holder Name: _____
Date of Birth: _____ Social Security #: _____
Employer: _____
Secondary Insurance: Company Name: _____
Policy Holder Name: _____
Date of Birth: _____ Social Security #: _____
Employer: _____