Downtown Seattle Dentists

509 Olive Way #1132
Seattle, WA 98101
(206) 447-9397

Patient Registration Form

Email:	Today's Date:
☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.	Referred by:
Name:	Preferred name:
Address:	City: State: Zip:
SS#:	Date of Birth: Sex: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
Home Phone #	Cell phone #
Employer:	Business Phone: ( )
Emergency Contact:	Relationship: Phone #: ( )
Whom May We Thank for Referring You?	

Financially Responsible Party

Person Responsible for this Account:	Date of Birth:
Relationship to Patient:	Is this Person a Patient in our Office?
Address:	City: State: Zip:
Home Phone Number: ( )	Work Phone Number: ( )
Employer:	

We expect patient portion not covered by insurance at time of service

Insurance Information (Dental Only)

Name of Insured:	SS#:
Relationship to Patient:	Date of Birth:
Name of Employer:	Work Phone #: ( )
Insurance Company:	Group #:
Insurance Company Address:	
City: State:	Zip:
Insurance Company Phone #: ( )	
Have you been seen in another dental office this year?	
Name of office:	Office phone #: ( )

Secondary Dental Insurance

Name of Insured:	SS#:
Relationship to Patient:	Date of Birth:
Name of Employer:	Work Phone #: ( )
Insurance Company:	Group #:
Insurance Company Address:	
City: State:	Zip:
Insurance Company Phone #: ( )	