PATIENT REGISTRATION

Portal Family Dentistry & Orthodontics

First Name: _____ Last Name: _____ M.I._____

Patient is:

- o Policy Holder
- o Beneficiary

Parent or Responsible Party Information (If patient is under 18):

First Name: _____ Last Name: _____ M.I._____
Address: _____
City, State, Zip: _____
E-mail: _____ ☐ I would like to receive correspondences via e-mail
Cellphone: _____ ☐ I would like to receive correspondences via SMS
Home Phone: _____ Work Phone_____ Ext:_____
Date of birth: _____ SSN: _____ Drivers Lic. : _____

Patient Information:

First Name: _____ Last Name: _____ M.I._____
Address: _____
City, State, Zip: _____
E-mail: _____ ☐ I would like to receive correspondences via e-mail
Cellphone: _____ ☐ I would like to receive correspondences via SMS
Home Phone: _____ Work Phone_____ Ext:_____
Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed
Date of birth: _____ SSN: _____ Drivers Lic. : _____

---------- **Part 2** ----------

Emergency Contact:
Name: _____ Telephone: _____ Relationship_____

Reason for Consultation:_____
How did you find out about us? _____

_____
Patient or Responsible Party's signature