

CREATING BEAUTIFUL SMILES
Dr. Paul J Racine & Dr. Kenneth C. Ackley

www.cliodental.com

Welcome to the office of Drs. Racine & Ackley. So that we may provide you with the best possible care, please complete this patient registration form and the medical/dental history forms. All information is completely confidential. Thank you so much for the privilege to serve you!

Date: _____

Patient Information:

Name (Last) (First) (Middle) Preferred name / / M F
date of birth sex

S M W D
marital status social security number E-mail address

Address: _____

Phone Numbers: Home Work Cell

Responsible Party: _____

Address (if different than patient) _____

Phone #s: (if different than patient) _____
Home Work Cell

Primary Insurance Information:

Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Date of birth: _____ Employer: _____

Insurance Company Name: _____ Phone # _____

Insurance Contract ID#: _____ Group# _____

Relationship to patient: _____

Secondary Insurance Information:

Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Date of birth: _____ Employer: _____

Insurance Company Name: _____ Phone # _____

Insurance Contract ID#: _____ Group# _____

Relationship to patient: _____

In case of emergency call: _____

Name of close relative NOT living with you: _____ Phone# _____

How did you hear of our office? _____

What are your hobbies? Special interests? _____