JEFFREY H. LIND DMD
4130 LA JOLLA VILLAGE DR#202
LA JOLLA, CA 92037
858 535-1478

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________

Address: ______________________

City: ______________________ State / Zip: ______________________

Home Phone: (______)__________ Work Phone: (______)__________ Ext #______ CELL #: (______)__________

Occupation: ______________________

Employer: ______________________

Employer Address: ______________________

Sex ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed ❍ Domestic Partner

Birthdate: __________ Age: ______ Soc. Sec: ______________________

❒ I would like to receive correspondences via e-mail.

E-mail: ______________________

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Student Status: ❍ Full Time ❍ Part Time If student, where: ______________________

Responsible Party

First Name: ______________________ Last Name: ______________________

Relationship to Patient: ______________________

Address: ______________________

City: ______________________ State / Zip: ______________________

Home Phone: (______)__________ Work Phone: (______)__________ Ext #______ CELL #: (______)__________

Birthdate: __________ Soc. Sec: ______________________

Spouse/Significant Other (please use parent's name if under 18) ______________________

Whom do we contact for emergencies? ______________________

Phone number of emergency contact (______) ______________________

Closest relative not living with you ______________________

Phone number of closest relative (______)______________________

Full address of closest relative______________________

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Whom may we thank for referring you to our office? ______________________

DENTAL CARRIER	SECONDARY DENTAL INSURANCE
Subscriber's Name: __________	Subscriber's Name: __________
Subscriber's SSN #: __________	Subscriber's SSN #: __________
Employer Name: __________	Employer Name: __________
Employer Address: __________	Employer Address: __________
__________	__________
Employer Phone #:(______) __________	Employer Phone #:(______) __________
Insurance Carrier Name: __________	Insurance Carrier Name: __________
Insurance Phone #(______) __________	Insurance Phone #(______) __________
Insurance Group #__________	Insurance Group #__________
Subscriber DOB: __________	Subscriber DOB: __________

Print Form