LOMA LINDA UNIVERSITY
School of Dentistry

PATIENT REGISTRATION FORM

Instructions: Please print with black or dark blue ink.

Have you been a previous patient at the Dental School? ☐ **Yes** ☐ **No** **If yes, name used then if different:** _____

PATIENT INFORMATION

Last Name			First Name		Initial	Marital Status	
Address			Mailing Address (if different)				
City and State		Zip Code	City and State			Zip Code	
Area Code & Phone #	Area Code & Cell #	Area Code & Work #	Birth Date	Age	Gender	SSN	
E-Mail Address			Preferred Language			Ethnicity	
Employer			Occupation				

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Responsible Party - Last Name		Responsible Party - First Name	Middle Initial
Address		Mailing Address (if different)	
City and State	Zip Code	City and State	Zip Code

DENTAL INSURANCE INFORMATION

Insured's Name	Birth Date of Insured	Relationship	Insured's employer if insured not you
Insurance Company Name	Ins. Group No.	Ins. Co. Phone No.	SSN of Insured
Insured's Name	Birth Date of Insured	Relationship	Insured's employer if insured not you
Insurance Company Name	Ins. Group No.	Ins. Co. Phone No.	SSN of Insured
Insured's Name	Birth Date of Insured	Relationship	Insured's employer if insured not you
Insurance Company Name	Ins. Group No.	Ins. Co. Phone No.	SSN of Insured

COMMENT

PERSON TO CONTACT IN CASE OF EMERGENCY

First and Last Name	Relationship	Area Code & Phone #
Address	City and State	Zip code

Signature: _____ Date: _____