**Michael L. La Puma, D.M.D.**
**PATIENT REGISTRATION**

Welcome to our practice. **Today's Date:**

**PATIENT INFORMATION**

**Name**_____ **Birth Date**_____

I prefer to be called _____ SS#_____

Gender (circle one) MALE / FEMALE Age: _____ Height: _____Weight: _____

Address_____ Home Phone_____

City_____State_____Zip_____Cell Phone_____

Employer/School_____ Email_____

**Person to Contact in Case of Emergency** _____

Relationship to Patient _____Phone_____

**PARENT/SPOUSE INFORMATION**

**Parent/Spouse Name** _____

Address_____ Home Phone_____

City_____State_____Zip_____ Cell Phone_____

Employer _____ Email_____

**INSURANCE INFORMATION**

**Do you have dental insurance?** Yes No

Insurance Company_____Address_____

Subscriber's Name_____ SS#/ID#_____ DOB_____

Relationship to Patient_____ Group #_____

**Do you have additional dental insurance?** Yes No

Insurance Company_____Address_____

Subscriber's Name_____ SS#/ID#_____ DOB_____

Relationship to Patient_____ Group #_____

**Do you have medical insurance?** Yes No

Insurance Company_____Address_____

Subscriber's Name_____ ID#_____ DOB_____

Relationship to Patient_____ Group #_____

**Name/location of pharmacy you prefer** _____

**Name of general dentist** _____**Name of orthodontist**_____

**Name of periodontist**_____**Name of physician**_____

**Whom may we thank for referring you?** _____

Have you or anyone in your family ever been a patient of Dr. La Puma's before? □ Yes □ No

If yes, whom and what is their relationship to you? _____