R. Stevens Group, Inc.
Patient Registration

Patient

First Name: ____________________ Last Name: _____________________ Middle Initial: _____

Birth Date: ___/___/_______ Preferred Name (if different from above): ___________________

Address: ____ City, St., Zip: ____________________

Home Phone: ____-____-_________ Cell Phone: ____-____-_________

Other Phone: ____-____-_________ Email Address: ______________________________

Social Security #: ____-____-_________ Drivers License #: ___________________

Sex (circle): M F Marital Status (circle): single married divorced widowed separated

Responsible Person / Primary Insurance Holder *(if different from patient)*

First Name: ___________________ Last Name: _______________________ Middle Initial: ____

Birth Date: ___/___/_______ Relationship to Patient:_______________________________

Social Security #: ____-____-_________ Drivers License #: ___________________

Address: ____ City, State, Zip: _____________

Primary Phone: ____-____-_________ Alternate Phone: ____-____-_________

Dental Information

Reason for today's appointment: ____

____

Concerns about your dental/oral health: ____

____

Would you be interested in straightening your teeth with Invisalign? ______________________

Approx. date of last dental x-rays: ____________ Approx. date of last cleaning: ____________

How did you hear about our office? ____