Family Dentistry

Mark A. Schmidtke DDS

Suite 210, AdBel Plaza
1401 Matthews Township Parkway
Matthews, NC 28105
(704) 844-0014

Registration Form

Patient Information:

Mr. / Mrs. / Ms. / Dr. / Other

___/_____/___
DATE OF BIRTH

FIRST NAME MI LAST NAME

STREET ADDRESS APT # CITY STATE ZIP CODE

_____ _____ _____/_____/_____
HOME PHONE BUSINESS PHONE SOCIAL SECURITY NUMBER

_____
CELL PHONE

Do you have dental insurance? __Yes__No

Referred by: _____

_____
EMAIL ADDRESS

Person responsible for payment of services:

FIRST NAME MI LAST NAME

STREET ADDRESS APT # CITY STATE ZIP CODE

_____ _____ _____/_____/_____
HOME PHONE BUSINESS PHONE SOCIAL SECURITY NUMBER

Emergency contact:

FIRST NAME MI LAST NAME RELATIONSHIP

_____ _____

HOME PHONE BUSINESS PHONE

The information entered above is current to my knowledge, and I understand that all information contained in the dental record will remain strictly confidential. Furthermore, with my signature I hereby acknowledge that I have read and understand the policies for this practice, and agree to comply with them.

_____ _____/_____/_____
SIGNATURE DATE