SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Patient Registration Information – Please Print using black or blue ink

Title	Patient's Last Name	First Name	Middle	Preferred	Gender

Date of Birth	Social Security No.	Marital Status	Email Address

Home Address	Apt or Box No.	City	State	Zip Code

Home Phone Number _____ Daytime Phone Number _____ Cell Phone Number _____

Preferred Method of Contact:
Text me at _____ Send me an email at _____@_____ Call me at _____

Emergency Contact – Name Relation Daytime Phone No. Address (Street, City, State, Zip)

Race/Ethnicity (optional)
Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Hispanic / Latin / Spanish Yes ☐ No ☐

Guardian Information

Title	Last Name	First Name	Middle	Relation	Gender

Date of Birth	Social Security No.	Marital Status		

Home Address	Apt or Box No.	City	State	Zip Code	Email Address

Home Phone Number Daytime Phone Number Cell Phone Number Preferred Contact Number

Patient's Primary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient

Patient's Secondary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient