

**New Patient Registration Form**  
**Market Street Dental**  
**Paul L. Boger, DMD ◦ Ashley M. Church, DMD**

Welcome and thank you for choosing Market Street Dental to meet your dental needs.

Today's Date \_\_\_\_\_ May we ask how you heard of us? \_\_\_\_\_

**Patient Information**

\_\_\_\_\_  
First Last MI DOB SS#

\_\_\_\_\_  
Address City State Zip Code

( ) ( ) ( ) \_\_\_\_\_  
Home Phone Cell Phone Work Phone Email address

Home Phone Cell Phone Work Phone Email address

May we text you to confirm your appointments? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Emergency Contact Relationship Phone

**Are you required to pre-medicate (ie take an antibiotic) prior to dental treatment? Yes No**

**Financial Responsibility for account**

\_\_\_\_\_  
Responsible Party's Name SS# Relationship to Patient

\_\_\_\_\_  
Mailing Address Phone

Signature \_\_\_\_\_

**Responsibility for dental/medical decision-making**

If the patient is a minor or otherwise unable to make medical/dental decisions for him or herself, please indicate the person(s) who is (are) legally responsible for making medical and dental decisions on his or her behalf.

Name(s) \_\_\_\_\_ Relationship(s) to patient \_\_\_\_\_

Address & Phone # (if different from above): \_\_\_\_\_

Signature(s): \_\_\_\_\_