Distinctive Dental Services of New York, P.C.
173 East Shore Road, Suite 201 Great Neck, NY 11023

Patient # ___________

PATIENT REGISTRATION FORM

Mary George, D.M.D./Pediatric Dentistry
Gina Sajnani, D.M.D./Pediatric Dentistry

Derek Zimbardi, D.D.S./General Dentistry
Cristina David, D.D.S./General Dentistry

Ralph Epstein, D.D.S./Anesthesia

Date: ______________________

Pharmacy Phone #: ______________________

1. **Are any other family members patients in our office? Yes / No**
   If you do not wish to have all family members on the same family account, please inform the receptionist.
2. Name, address and relationship of referring doctor, friend, or family member: _____________________
   ____
3. Patient's Name: ____
   Last First MI
4. Patient's Address: ____
   Street Address City State Zip Code
5. Patient's email address: ____
6. Patient's Home Phone #: _____________________
7. Patient's Cell/Pager #: ___________________
8. Patient's Date of Birth: __________
9. Patient's Social Security #: ____________________
10. Patient's Marital Status: Single / Married / Other: ________________
11. Sex: Male / Female
12. Patient Employed by: ______________________
13. Patient's Work Phone #: _________________

GUARANTOR INFORMATION (Person responsible for the account, other than the patient):

14. Name: ____
    Last First MI
15. Address: ____
16. Home Phone #: _______________________
17. Cell/Pager #: __________________________
18. Guarantor's email address: __________________________________
19. Date of Birth: _______________
20. Social Security #: _______________________
21. Marital Status: Single / Married / Other: ___________
22. Sex: Male / Female
23. Employed by: ___________________________
24. Work Phone #: ______________________