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
Simone Reisman, D.D.S./Pediatric Dentistry

Tova Abdyan, D.D.S./General Dentistry
Diane Jin, D.D.S./General Dentistry

Ralph Epstein, D.D.S./Dental Anesthesthesiology

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 #: _____