Friesz Family & Cosmetic Dentistry
Jason L. Friesz, D.D.S., P.A.
2506–1st Street South
St. Cloud, MN 56301

REGISTRATION

Information is confidential, and important. Accurate answers are necessary for such matters and proper diagnosis, protection of your and our general health, efficiency, and optimum dental treatment. We welcome you as a patient and look forward to taking care of your dental needs.

DATE: _____

Circle One: Mr. Mrs. Miss Ms. Dr.

Patient Name_____
(Last) (First) (Middle)

Date of Birth : _____/_____/_____ Name Preferred; Nickname_____

Sex M_____F_____ Home Phone_____ Cell Phone_____

Texting Y_____ N _____ Email Address_____

Home Address_____
(Address – City – State – Zip)

Single _____ Married _____ Spouse's Name_____
(or parents name if child)

Occupation(s)_____

Employed by_____

If necessary, may we call you at work? Y_____N_____ Business Phone_____

Emergency Contact _____Phone_____
(Name)

Person(s) responsible for this account_____

(To whom statement should be sent)_____
(Address – City – State – Zip) (Phone)

Name of Dental Insurance_____

Policy ID #_____Group #_____

Referred by?_____ If personal reference, may we thank them? Y_____ N_____

Hobbies, interest, sports, talents:_____

_____

SIGNATURE _____