STACY KANDA, D.D.S.
2335 SW 320TH ST, SUITE #1 * FEDERAL WAY, WA 98023
(253) 661-2222

PATIENT REGISTRATION

PLEASE ANSWER EVERY QUESTION COMPLETELY

DATE____________

PATIENTS NAME____ ☐MALE ☐FEMALE
NICKNAME____________________BIRTHDATE_______________ AGE_______
SS #____________________ ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED
ADDRESS________________________________CITY_________________ STATE_____ZIP______
Apt/Condo #
LAND LINE #__________________CELL #_________________E-MAIL_____________________
DRIVER'S LICENSE NUMBER___________________________

WHERE CAN WE REACH YOU DURING THE DAY? ___________________________

PATIENT INFORMATION: (FATHERS INFORMATION IF PATIENT IS UNDER 18)

NAME_________________________________SS#__________________BIRTHDATE_____________
EMPLOYER_________________________WK #_______________EXT____ POSTION____________
CELL #________________________ E-MAIL __________________________________

SPOUSES INFORMATION: (MOTHERS INFORMATION IF PATIENT IS UNDER 18)

NAME_________________________________SS#_________________BIRTHDATE______________
EMPLOYER_________________________WK #_______________EXT____ POSTION_____________
CELL#________________________E-MAIL__________________________________

IF PATIENT IS A CHILD, WHICH PARENT DOES THE CHILD RESIDE WITH?
☐ BOTH ☐MOTHER ☐FATHER ☐OTHER_____________________________

IS PATIENT OVER 18 AND ATTENDING COLLEGE ON A FULL TIME BASIS? ☐YES ☐NO
IF YES: SCHOOL NAME: __________________________CITY__________________STATE_____

(PLEASE CONTINUE ON THE BACK)