Harry A. Haralampopoulos, D.D.S., P.C.
And Associates
Periodontics Endodontics Implant Dentistry

Patient Registration:

Name _____M _____F _____

Street Address _____ City _____

State _____Zip Code _____ Home # _____Cell # _____

Email Address _____

Date of Birth _____ Social Security # _____

Married _____Single _____Widowed _____Divorced _____

Employer Name/Address _____

Occupation _____ Business Phone # _____

Spouse Name _____

Employer Name/Address _____

Occupation _____

How were you referred to our office? _____

Insurance Information:

Primary Insurance:

Insurance Company _____Group # _____

Name of Insured _____ Social Security # _____

Date of Birth _____ Insurance ID # _____

All accounts are to be paid in full at time of service.

The above information is correct to the best of my knowledge and I hereby give full permission for the scientific use of my treatment records, x-rays and photographs.

_____ _____

Signature of Patient/Responsible Party Date