



**KOENIGSKNECHT DENTISTRY**  
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102 East Cass  
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# REGISTRATION

NAME \_\_\_\_\_ E-MAIL \_\_\_\_\_

BIRTH DATE \_\_\_\_\_  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

CELL PH ( ) \_\_\_\_\_ HOME PH ( ) \_\_\_\_\_

RESIDENT ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_ PRESENT POSITION \_\_\_\_\_

NAME OF SPOUSE, PARENT OR GUARDIAN \_\_\_\_\_

ADDRESS (if different than above) \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_ PRESENT POSITION \_\_\_\_\_

PATIENT OR PARENT SOCIAL SECURITY NUMBER \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

WHO WILL PAY FOR THIS ACCOUNT \_\_\_\_\_

NAME OF DENTAL INSURANCE COMPANY \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

REFERRED BY \_\_\_\_\_ IF NO REFERRAL, HOW DID YOU CHOOSE OUR OFFICE \_\_\_\_\_