DENTAL TECHNOLOGY CENTER
OF HAWAII

1314 S. King St., Suite 724 Honolulu, Hi 96814
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Patient Registration

Name: _____ Date of Birth: _____

Address: _____ City: _____ St: ____ Zip: _____

Is your mailing address listed above the same as your physical address?

If no, please list your physical address below.

Address: _____ City: _____ St: _____ Zip: _____

Contact #: (H) _____ (C) _____ Email: _____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Employer: _____ Work # _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Spouse's Contact #: _____

Person financially responsible for this account: _____

Who may we thank for your referral? _____

In case of an emergency, who may we contact for you?

Emergency contact name: _____

Relationship: _____ Phone #: _____

Do you have Medical Insurance? Y _____ N _____
(if yes, please provide your card to our team member so we may scan a copy of your medical card)

As a courtesy, Dental Technology Center (DTC) of Hawaii will submit a medical claim for services rendered today to your medical insurance carrier. Your signature below acknowledges and gives DTC permission to submit for services rendered on your behalf and for payment to be mailed directly to DTC.

X_____ Date: _____
Signature of Patient or Parent/Guardian for minors under 18yrs old