

Cache Valley Smile Design

Dr. Matthew Cheney, DMD

New Patient Registration

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Home phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Social Security Number: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

How did you hear about our office?



Responsible Party: Same as Patient

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Home phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Social Security Number: _____

*We offer access to your account and appointment
information on our website www.drcheneydmd.com*

Email address (required to gain access): _____



Authorization and Release: I certify that I have read and understand the above information. I have answered the questions to the best of my knowledge and understand that incorrect information may endanger my health.

Patient, Parent or Guardian: _____ Date: _____