PATIENT REGISTRATION

Patient Information

First Name:____________________Last Name:__________________________________Middle Initial:_______
Preferred Name:__________________________
Address:_____________________________________Address 2:____
City, State, Zip:____
Home Phone:_________________Work Phone:________________Ext:_______Cell:_______________________
Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
Birth Date:_____________Age:______Soc Sec:___________________Drivers Lic:________________________
Email:____❑ I would like to receive correspondences via e-mail.
Patient Is: ❑ Policy Holder ❑ Responsible Party ❑Dependent ❑Spouse
Referred By:_____________________________ Previous Dentist:______________________________________
Emergency Contact Name and Phone:____________________________________Relation:_________________

Responsible Party(if other than patient)

First Name________________________Last Name_________________________________Middle Initial:______
Address:____________________________________Address 2:____
City, State, Zip:____
Home Phone:_________________Work Phone:________________Ext:_______Cell:______________________
Birth Date:_____________Soc Sec:___________________Drivers Lic:________________________________
❑ Responsible Party is also a Policy Holder for Patient ❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired
Student Status: ❑ Full Time ❑ Part Time

Employer Information

Name:____
Address:_____________________________________Address 2:____
City, State, Zip:____
Home Phone:_________________Work Phone:_________________Ext:_______Cell:______________________

Primary Insurance Information

Name of Insured:___________________________Relationship to Insured:❑ Self ❑ Spouse ❑ Child ❑ Other
Insured SS#_______________________Insured Birth Date:____________________
Employer:__________________________________
Address:___________________________________ Address:___________________________________
City, State, Zip:______________________________

Ins Carrier:_______________________________________ID #_____________________________________
Address:___________________________________ _____Goup #:___________________________________
City, State, Zip:______________________________
Rem. Benefits:________00 Rem. Deduct: ________00

Secondary Insurance Information

Name of Insured:___________________________Relationship to Insured:❑ Self ❑ Spouse ❑ Child ❑ Other
Insured SS#_______________________Insured Birth Date:____________________
Employer:__________________________________
Address:___________________________________ Address:___________________________________
City, State, Zip:______________________________

Ins Carrier:_____________________________________ID #______________________________________
Address:___________________________________ Group #___________________________________
City, State, Zip:______________________________
Rem. Benefits:________00 Rem. Deduct: ________00