TOPSAIL DENTAL

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____

Patient Information:

Address: _____ Address 2: _____
City: _____ State/Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Gender: ○ Male ○ Female
Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed
To receive correspondence via email, please provide email address: _____
Employment Status: ○Full-time ○Part-time ○Retired ○Unemployed ○Disabled
Student Status: ○Full-time ○Part-time ○None If student: Name of School _____
Previous Dentist: _____ Date of Last Dental Visit: _____
Preferred Pharmacy: _____ Pharmacy # (if known): _____
Emergency Contact: _____ Emergency Contact #: _____

Responsible Party (if someone other than patient):

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Relationship to Patient: ○Spouse ○Parent ○Insurance Holder ○Other (please specify) _____

Primary Dental Insurance Information:

Name of Insured: _____
Relationship to Insured: ○Self ○Spouse ○Child ○Other (please specify) _____
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____

***Please provide us with your insurance card so we may make a copy for your records**

Secondary Dental Insurance Information:

Name of Insured: _____
Relationship to Insured: ○Self ○Spouse ○Child ○Other (please specify) _____
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____

***Please provide us with your insurance card so that we may make a copy for your records**