

PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____ Home Phone: _____

Work Phone: _____ ext. _____ Cell/pager: _____

Sex: Male Female Marital status: Married Single Divorced Separated Widowed

Birth Date: _____ Soc. Sec: _____ Driver's License: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Employment Status: Full Time Part Time Retired Employer: _____

Student Status: Full Time Part Time Name of School: _____

Are you responsible for payment? Yes No If no, complete responsible party section below.

Do you have Dental Insurance? Yes No If yes, complete insurance information section below.

RESPONSIBLE PARTY (person responsible for account)

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____ Home Phone: _____

Work Phone: _____ ext. _____ Cell/pager: _____

Birth Date: _____ Soc. Sec: _____ Driver's License: _____

E-mail: _____ Relationship to Patient: Spouse Parent Other _____

INSURANCE INFORMATION (policy holder)

If you would like us to assist you in filing your dental insurance claims for direct reimbursement, please complete the following information. We will also need a copy of your insurance card on file.

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Employer City/State: _____

Name of Insurance Company: _____ Group #: _____

Relationship of Patient to Insured: Self Spouse Child Other _____

How did you hear about us?

Yellow Pages

Talking Phone Book

Internet

Bellsouth

UNC Directory

Patient / Friend / Other

Name: _____