PATIENT REGISTRATION

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

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

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

City: _____ State / Zip: _____ _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female ☐ Other: _____ Pronouns: _____

Birth Date: _____ Age: _____ Soc Sec: _____

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

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Occupation: _____

How did you hear about us? _____

Pref. Pharmacy: _____

Section 3

Previous Dentist (Name and Location): _____

Approximate Date Last Seen: _____

Reason For Leaving: _____

May we contact them to request your records? _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insured ID #: _____ Group #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company Phone: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insured ID #: _____ Group #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company Phone: _____