

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: _____ Cell: _____
Sex: Male Female Other: _____ Pronouns: _____
Birth Date: _____ Age: _____ Soc Sec: _____
E-mail: _____ I would like to receive correspondences via e-mail.

Emergency Contact Information Name: _____ Phone Number: _____ Relationship: _____
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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: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ Address 2: _____
Insured ID #: _____ Group #: _____ 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: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ Address 2: _____
Insured ID #: _____ Group #: _____ City, State, Zip: _____
Ins. Company Phone: _____