PATIENT REGISTRATION

PATIENT INFORMATION:

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

Birthdate: _____ **Social Security Number:** _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____ **EXT:**_____

Sex: ☐ Male ☐ Female ☐ Other **Employer:** _____ **Occupation:** _____

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

Referred By: ☐ Google ☐ Facebook ☐ Mail ☐ Yellow Pages ☐ Insurance Co ☐ Family/Friend/Other: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Preferred Pharmacy: _____

RESPONSIBLE PARTY: Patient is: ☐ Responsible party

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

Relation to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: ____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____

ID Number/Member ID: _____

Policy Holder Name: _____

Policy Holder Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

IN OFFICE SIGNATURES:

I have read and understand the Notice of Privacy Practices and Authorization (HIPAA).

Signature: _____ **Date**: _____

Relationship to Patient: _____

I give consent to Warrenton Family Dentistry to notify/contact me via unencrypted email or text which may include personal health information. (Ex: Appointment reminders, notifications)

Signature: _____ **Date**: _____

Relationship to Patient: _____