Fairbourn Family Dentistry

PATIENT REGISTRATION

First Name: ____________ **Last Name:** ____________ **Middle Initial:** ______

Preferred Name: ____________ **Emergency Contact Name:** ____________ **Phone:** ______

Patient is : ☐ Responsible Party ☐ Policy Holder

Responsible Party: Parent or Guardian *(if someone other than the patient)*

First Name: ____________ Last Name: ____________ Middle Initial: ______

Address: ____________

City, State, Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Birth date: ____________ **Social Security #:** ____________ **Drivers Lic#:** ____________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: ____________

City, State, Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ____________ **Social Security #:** ____________ **Drivers Lic#:** ____________

E-mail: ____________ ☐ **I would like to receive email correspondences**

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Pharmacy: ____________

How did you hear about us? Internet? Friend? (name) ____________ **Yellow Pages? Other?** ______

Member/Subscriber ID: ____________

Primary Dental Insurance Information:

Name of Insured: ____________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ____________ Carrier ID: ____________

Insured Social Security #: ____________ **Insured Birth date:** ____________

Employer: ____________ **Insurance Company:** ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City, State, Zip: ____________ City, State, Zip: ____________