PATIENT REGISTRATION

Patient is: □ **Responsible Party** □ **Insurance Policy Holder** □ **Dependent (Child)**

PATIENT INFORMATION:

First Name:_____ **Last Name:**_____

Middle Name:_____ **Preferred Name:**_____

Mailing Address:_____

City/State/Zip:_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **Email:**_____
□ **I would like to receive correspondence via Text and Email.**

Birth Date:_____ **Social Security #:**_____

Sex: □ **Male** □ **Female** **Marital Status:** □ **Married** □ **Single** □ **Divorced** □ **Separated** □ **Widowed**

Insurance: □ **Primary Ins. Policy Holder** □ **Secondary Ins. Policy Holder**

RESPONSIBLE PARTY INFORMATION (if someone other than the patient):

First Name:_____ **Last Name:**_____

Mailing Address:_____

City/State/Zip:_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **Email:**_____
□ **I would like to receive correspondence via Email.**

Birth Date:_____ **Social Security #:**_____

PATIENT INFORMATION CONTINUED:

Employment Status: □ **Full Time** □ **Part Time** □ **Retired**

Student Status: □ **Full Time** □ **Part Time**

Preferred Dentist:_____ **Preferred Hygienist:**_____

Preferred Pharmacy:_____ **Pharmacy Phone#:**_____

PRIMARY INSURANCE INFORMATION:
(Please provide our front desk with your insurance card so that we may have a copy on file.)

Name of Insured:_____

Relationship to Insured: □ **Self** □ **Spouse** □ **Child** □ **Other:**_____

Insured Social Security #:_____ **Birth Date:**_____

Dental Insurance Member ID #:_____ **Group ID #:**_____

Employer:_____ **Ins. Co.:**_____

Address:_____ **Address:**_____

City/State/Zip:_____ **City/State/Zip:**_____

Contact #:_____ **Contact #:**_____

Summary of Benefits: _____

Rem. Benefits:_____ **Rem. Deductible:**_____

SECONDARY INSURANCE INFORMATION:
(Please provide our front desk with your insurance card so that we may have a copy on file.)

Name of Insured:_____

Relationship to Insured: □ **Self** □ **Spouse** □ **Child** □ **Other:**_____

Insured Social Security #:_____ **Birth Date:**_____

Dental Insurance Member ID #:_____ **Group ID #:**_____

Employer:_____ **Ins. Co.:**_____

Address:_____ **Address:**_____

City/State/Zip:_____ **City/State/Zip:**_____

Contact #:_____ **Contact #:**_____

Summary of Benefits:_____

Rem. Benefits:_____ **Rem. Deductible:**_____