PATIENT REGISTRATION

Patient Information:

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

Preferred Name: _____ Sex (circle one): Male Female

Marital Status (circle one): Single Married Divorced Separated Widowed

Mailing Address (include City, State, Zip): _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____/_____/_____ (MM/DD/YYYY) Social Security #: _____-_____-_____

Employment Status (circle one): Full-Time Part-Time Self Employed Retired Unemployed

Responsible Party (if someone other than patient OR parent/guardian if patient is a MINOR):

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

Mailing Address (include City, State, Zip): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____/_____/_____ (MM/DD/YYYY) Social Security #: _____-_____-_____

Relationship to Patient (circle one): Parent/Guardian Spouse Other: _____

Preferred Pharmacy: _____ Referred By: _____

Previous Dentist: _____ Last Cleaning: _____

Primary DENTAL Insurance Information:

Name of Policy Holder: _____ Relationship to Insured (circle one): Self Spouse Child Other

Group #: _____ Member/Subscriber ID: _____

Insured SSN #: _____-_____-_____ Insured Birth Date: _____/_____/_____ (MM/DD/YYYY)

Employer: _____ Insurance Company Name: _____

Secondary DENTAL Insurance Information:

Name of Policy Holder: _____ Relationship to Insured (circle one): Self Spouse Child Other

Group #: _____ Member/Subscriber ID: _____

Insured SSN #: _____-_____-_____ Insured Birth Date: _____/_____/_____ (MM/DD/YYYY)

Employer: _____ Insurance Company Name: _____