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: ____________________