PATIENT REGISTRATION FORM

Patient Information Date: _____

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Soc. Sec #: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondences via email.

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired ◯ Not Applicable

Student Status: ◯ Full Time ◯ Part Time ◯ Not Applicable

Responsible Party (if someone other than patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Age: _____ Soc. Sec #: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondences via email.

Additional Information

Referred To Our Office By: _____ Previous Dentist: _____ Previous Office: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Pref. Dentist: _____ Pref. Hygienist: _____ Pref. Pharmacy: _____

Primary Insurance Information ☐ I do NOT have insurance to file

Subscriber's Name: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber's Soc. Sec #: _____ Policy ID #: _____ Subscriber's Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Subscriber's Name: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber's Soc. Sec #: _____ Policy ID #: _____ Subscriber's Birth Date: _____

Employer: _____ Ins. Company: _____