

Patient Registration

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____
Address: _____ Preferred Name: _____
City, State, Zip: _____
Home Phone Number: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Emergency Contact: _____ Contact Phone #: _____
E-Mail: _____ I would like to receive correspondences via e-mail
How did you hear about our office? _____

RESPONSIBLE PARTY (If different from patient)

First Name: _____ Last Name: _____ MI: _____
Address: _____
City, State, Zip: _____
Home Phone Number: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Birth Date: _____ Social Security Number: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured: _____ Relationship to Patient: Self Spouse Parent Other
Address: _____ Home Phone Number _____
Birth Date: _____ Employer: _____
Insurance Company: _____
Insurance Company Address: _____
Insurance Company Phone Number: _____ Group #: _____
Insured Social Security Number: _____ Policy/Subscriber ID#: _____

SECONDARY INSURANCE

Name of Insured: _____ Relationship to Patient: Self Spouse Parent Other
Birth Date: _____ Employer: _____
Insurance Company: _____
Insurance Company Address: _____
Insurance Company Phone Number: _____ Group #: _____
Insured Social Security Number: _____ Policy/Subscriber ID#: _____