PATIENT REGISTRATION

Patient Information

Patient's Name: _____ Preferred Name: _____
First Middle Last

Patient's Address: _____

City, State, Zip: _____

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

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

Birth Date: _____ Age: _____

Social Security #: _____ Driver's License # / State: _____

Employment Status: ☐ N/A ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time Where: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Responsible Party Information (if someone other than patient):

Name: _____
First Middle Last

Address: _____

City, State, Zip: _____

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

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

Birth Date: _____ Age: _____

Social Security #: _____ Driver's License # / State: _____

Employment Status: ☐ N/A ☐ Full Time ☐ Part Time ☐ Retired

Relationship To Patient: _____

Primary Insurance Information

Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Employer/Subsciber ID #: _____

Insurance Company: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Group #: _____

Secondary Insurance Information

Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Employer/Subsciber ID #: _____

Insurance Company: _____
Address: _____
Address 2: _____
City, State, Zip: _____
Group #: _____

UNLESS WE ARE A PREFERRED PROVIDER WITH YOUR INSURANCE COMPANY, PAYMENT IS DUE AT TIME OF SERVICE.

Additional Information

Whom may we thank for referring you? _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: # Home:Work: _____ Cellular: _____

Preferred Dentist: _____ Preferred Hygienist: _____

Preferred Pharmacy and Phone: _____

E-mail: _____

☐ I would like to receive correspondences via e-mail.