PATIENT REGISTRATION

Patient Information:

First Name:____________________________Last Name:____________________________Middle Initial: __

Preferred Name: ____

Patient is: □ Responsible Party □ Policy Holder

Address: ____Address 2:_____________________________

City, State, Zip: ____

Home Phone:____________________Work Phone:____________________Cell Phone: _______________

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

Birth date:________________Social Security #:_______________________Drivers Lic#:_______________

E-mail:____□ I would <u>not</u> like to receive email correspondences

Preferred Hygienist? _____________Preferred Pharmacy Name/Phone Number:__________________________

How did you hear about the practice?____

Responsible Party: (if someone other than the patient)

First Name:____________________________Last Name:____________________________Middle Initial:__

Address: ____________________________________Address 2:____________________________________

City, State, Zip:____

Home Phone:____________________Work Phone:____________________Cell Phone:_________________

Birth date:________________Social Security #:_______________________Drivers Lic#:________________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Dental Insurance Information:

Name of Insured:_______________________________Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security or ID #: _________________Insured Birth date: ____________________

Employer:____________________________________Insurance Company: ____________________________

Address:_____________________________________Ins. Address: _____________________________________

Address 2: ___________________________________Ins. Address 2: ____________________________________

City, State, Zip:________________________________Ins. City, State, Zip: _________________________________

Secondary Dental Insurance Information:

Name of Insured:_______________________________Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security or ID #: _________________Insured Birth date: ________________________________

Employer:____________________________________Insurance Company: _______________________________

Address:_____________________________________Address: ____

City, State, Zip:________________________________City, State, Zip:___________________________________