PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Name: _____

Patient is: □ Responsible Party □ Policy Holder Preferred Name: _____

Responsible Party: (if someone other than the patient)

First Name: _____Last Name: _____Middle Name: _____

Address: _____ 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

Patient Information:

Address: _____ 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 like to receive email newsletters

□ I would like to receive text appointment reminders □ I would like to receive email appointment reminders

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Employer: _____ Employer Phone Number: _____

Preferred Dentist: _____Preferred Hygienist: _____Preferred Pharmacy: _____

Referred By: _____

Person to Contact in Case of Emergency: _____ Phone: _____

□ I am available at short notice for my appointments

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

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

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

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

Signed By: _____ Date: _____