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# Patient Registration

(PLEASE PRINT ALL ANSWER)

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

Preferred Name: _____ Who referred you to us? _____

Patient Is: □ Policy Holder □ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cellular: _____ Other Phone: _____

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

○Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder

Patient Information

Address: _____

City: _____ State: _____ Zip: _____ Cellular: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○Part Time

Preferred Dentist: _____

Preferred Pharmacy: _____

Preferred Hygienist: _____

Previous Dentist: _____

Previous Dentist Location:

_____

Emergency Contact #: _____

Emergency Contacts Name:

_____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer:

_____

Address: _____

City, State, Zip:

_____

Insurance Company: _____

Address: _____

City, State, Zip:

_____

Insurance ID#: _____