PATIENT REGISTRATION

Patient Information:

Last Name: ___________________________

First Name: ___________________ Birth Date: _________ ☐ F ☐ M Age: _____ Preferred Name: _______________

First Name: ___________________ Birth Date: _________ ☐ F ☐ M Age: _____ Preferred Name: _______________

First Name: ___________________ Birth Date: _________ ☐ F ☐ M Age: _____ Preferred Name: _______________

First Name: ___________________ Birth Date: _________ ☐ F ☐ M Age: _____ Preferred Name: _______________

Responsible Party:

First Name:___________________________ Last Name: ____________________________ Middle Initial: ___________

Address: ____

City, State, Zip: ____

Preferred Phone: _________________________________ Secondary Phone: ___________________________________

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

Birth date: ______________________________________ Social Security #: _______________________________________

E-mail: _____________________________________ ☐ I would like to receive email correspondences

How did you hear about us?____

Primary Dental Insurance Information:

Name of Policyholder: _______________________ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child ☐ Other

Policy ID Number: ________________________________ Policy Holder SSN: __________________________

Policy Holder Birth date: ____________________________

Employer: ______________________________________	Insurance Company: _____________________________
Address: _______________________________________	Address: _______________________________________
Address 2: _____________________________________	Address 2: ______________________________________
City, State, Zip: _________________________________	City, State, Zip: _________________________________

Secondary Dental Insurance Information:

Name of Policyholder: _______________________ Patient's relationship to policyholder: ☐Self ☐Spouse ☐Child ☐ Other

Policy ID Number: ________________________________ Policy Holder SSN: __________________________

Policy Holder Birth date: ____________________________

Employer: ______________________________________	Insurance Company: _____________________________
Address: _______________________________________	Address: _______________________________________
Address 2: _____________________________________	Address 2: ______________________________________
City, State, Zip: _________________________________	City, State, Zip: _________________________________