PATIENT REGISTRATION

Patient Information:

First Name: ______________________ Last Name: _____________________ Middle Initial: ____

Preferred Name:__________________

Patient is: ☐ Responsible Party ☐ Policy Holder

Address: ____________________________________ City, State, Zip: ____________________________________

Home Phone: __________________ Work Phone: ____________________ Cell Phone: _____________ ☐Text

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

Birth date: ______________________ Social Security #: ________________________

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

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

Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy: ________________________ Previous Dentist: __________________________________

Referred By: _________________________________ Last Dental Visit and X-Rays: ____________________

Responsible Party: (if someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Address: _______________________________ City, State, Zip: ____

Home Phone: _______________ Work Phone: __________________ Cell Phone: _____________ ☐ Text

Birth date: ____________________ Social Security #: ____________________

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: ______________________________