Patient Registration

First Name: ______________________ Last Name:__________________ Middle Initial: ________
Preferred Name:_________________________
Patient Is: ____ Policy Holder ___ Responsible Party___ Neither_____________

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:________________
Birth Date: ______________ Soc Sec:_______________________ Drivers License:_____________
___ Responsible Party is Policy Holder for Patient __Primary Insurance Policy Holder __ Secondary Policy Holder

Patient Information

Address: ___________________________________ Address 2:___________________________
City: ______________________ State/ Zip: ________________________
Home Phone: ______________________ Work Phone: __________________ Cell: _________________
Sex: ___Male ___ Female
Marital Status:___ Married ___ Single ___ Divorced ___ Separated ___ Widowed
Birth Date: ______________ Age: _______ Soc. Sec: ___________________ Drivers License:_______________
EMAIL: _____________________________ For patient confirmation of appointments and specials
Accepts Text Message: _______
Previous Dentist: _____________________ Phone Number: ____________________________
Preferred Pharmacy: _______________________ Phone Number:________________________
Employment Status______ Full Time ______ Part Time ____ Retired
Employer:___________________________ Employer Address: _______________________________
Occupation:____
Student Status: ______ Full Time ___ Part Time

Primary Insurance Information

Name Of Insured: _______________________ Relationship to Insured: __ Self ___ Spouse ___ Child ___ Other
Insured Social Security: ______________________ Insured Birth Date: _____________
Insured ID number: __________________________ Group Number: ______________
Insurance Company: ____________________________
Address: _______________________________
Address 2:____________________________________
City, State, Zip: ________________________________

Secondary Insurance Information

Name Of Insured: _______________________ Relationship to Insured:__ Self ___ Spouse ___ Child ___ Other
Insured Social Security: ______________________ Insured Birth Date: _____________
Insured ID Number: __________________________ Group Number: __________________
Insurance Company: ____________________________
Address: _______________________________
Address 2:____________________________________
City, State, Zip: ________________________________