PATIENT REGISTRATION

PATIENT INFORMATION

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

Preferred Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City, State, Zip: _____

Home Phone:_____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Occupation: _____

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

Student Status: F/T ☐ P/T ☐ School Name: _____

General Dentist: _____ Phone: _____

Referred by: _____

Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY

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

Address: _____

City, State, Zip: _____

Home Phone:_____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured: _____

Insured Social Security/ID Number: _____ Birth Date: _____

Address: _____

Employer: _____

Insurance Company: _____

Insurance Company Phone Number: _____

Relationship to the Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance

Name of Insured: _____

Insured Social Security/ID Number: _____ Birth Date: _____

Address: _____

Employer: _____

Insurance Company: _____

Insurance Company Phone Number: _____

Relationship to the Patient: Self ☐ Spouse ☐ Child ☐ Other ☐