PATIENT REGISTRATION

FIRST NAME:_________________________________ LAST NAME:________________________________ MIDDLE INITIAL:_____

PATIENT IS: (check one) Preferred Name:_____________________________

POLICY HOLDER RESPONSIBLE PARTY

RESPONSIBLE PARTY (if someone other than the patient)

First Name: ___________________________________ Last Name: __________________________________ Middle Initial: ______

Address:____

City:____ State:_________ Zip:________________

Home Phone: _______________________ Work Phone: _______________________ Ext: _______ Cellular: ___________________

Birth Date: __________________________ Soc. Sec: ___________________________ Driver's License: ______________________

RESPONSIBLE PARTY IS: (check one)

also a policy holder for patient primary insurance holder secondary insurance policy holder

PATIENT INFORMATION

Address: ____

City: ____ State:_________ Zip:_________________

Home Phone: __________________________ Work Phone: __________________________ Ext: _______ Cellular: _________________

SEX: (check one)

Male Female

Birth Date: _____________________ Age: _______ Soc. Sec: ________________________ Driver's License: ______________________

E-mail: ____

EMPLOYMENT STATUS: (check one) STUDENT STATUS: (check one)

Yes No Other Full Time Part Time

NAME OF SCHOOL (if applicable):____

Pref. Dentist: ____ Referred By: ____________________________________

Pref. Parmacy: ______________________________________ Previous Dentist: ____________________________________

Pref. Hygentist: ______________________________________ Emergency Contact: ____________________________________

Emergency Contact #: ____________________________________

PRIMARY INSURANCE INFORMATION

Name of Insured: ____________________________________

Insured Soc. Sec: ___________________________________

Insured Date of Birth: ________________________________

Relationship to Insured: (check one)

Self Spouse

Child Other

Employer: ____

Address: ____________________________________

Address 2: ____________________________________

City, State, Zip: ____________________________________

Ins. Company: ____

Member ID #:____

Address: _______________________________________

Address 2: _______________________________________

City, State, Zip: _______________________________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ____________________________________

Insured Soc. Sec: ___________________________________

Insured Date of Birth: ________________________________

Relationship to Insured: (check one)

Self Spouse

Child Other

Employer: ____

Address: ____________________________________

Address 2: ____________________________________

City, State, Zip: ____________________________________

Ins. Company: ____

Address: _______________________________________

Address 2: _______________________________________

City, State, Zip: _______________________________________