Patient Registration

Patient Information:

First name:_____ Last name: _____ Middle Initial:_____
Address:_____
City, State, Zip:_____
Home phone:(___) _____ -_____ Work phone: (___)_____-_____ Cell: (____)_____-_____
Email Address:_____
Birth date: _____ Social Security #: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
Student Status: ☐ Full Time ☐ Part Time School:_____
Do you use a pre-medication prior to dental treatment? _____

Responsible Party:

☐: Same as above

First name:_____ Last name: _____ Middle Initial:_____
Address:_____
City, State, Zip:_____
Home phone:(___) _____ -_____ Work phone: (___)_____-_____ Cell: (____)_____-_____
Birth date: _____ Social Security #: _____
☐ Responsible Party is also the Policy Holder for Patient
☐ Primary Insurance Holder
☐ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Insured:_____
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insured SSN:_____ Insured Date of Birth: _____
Employer:_____ Insurance Company:_____
Insurance phone number: _____ Group number:_____
Subscriber ID #:_____

Secondary Insurance Information

Name of Insured:_____
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insured SSN:_____ Insured Date of Birth: _____
Employer:_____ Insurance Company:_____
Insurance phone number: _____ Group number:_____
Subscriber ID #:_____

Patient or Guardian Signature: _____