Patient Registration

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

Preferred Name: _____ Patient is: ☐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:_____ Cell Phone: _____

Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

☐ Responsible Party is also a Policy Holder for the Patient

○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

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

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext:_____ Cell Phone: _____

Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

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

E-mail: _____ ☐I would like to receive correspondence via e-mail

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Other Student Status: ○Full Time ○Part Time

Emergency Contact_____ Relation to Patient_____

Emergency Phone #_____

Preferred Hygienist: _____ Preferred Pharmacy: _____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc Sec: _____ Insured Birth Date: _____

Employer_____

Insurance Company: _____

Insurance Phone #: _____

Insurance Address: _____

City, State, Zip: _____

Member ID #:_____ Group #: _____

Remaining Benefits: _____ Remaining Deductible: _____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc Sec: _____ Insured Birth Date: _____

Employer_____

Insurance Company: _____

Insurance Phone #: _____

Insurance Address: _____

City, State, Zip: _____

Member ID #:_____ Group #: _____

Remaining Benefits: _____ Remaining Deductible: _____