



## PATIENT REGISTRATION

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Patient Is: ☐ Policy Holder ☐ Responsible Party

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

I would like to receive correspondences via (check all that apply): ☐ E-mail ☐ Text ☐ Phone Call

Sex: ☐ Male ☐ Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ State/Driver's License #: \_\_\_\_\_

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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

Preferred Hygienist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

☐ Responsible Party is the Policy Holder for Patient ☐ Primary Ins. Policy Holder ☐ Secondary Ins. Policy Holder

### Primary Dental Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Group #: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

### Secondary Dental Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Group #: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

X \_\_\_\_\_  
Signature of Patient (parent or legal guardian if minor) Today's Date