PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

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

Birth date: Social Security #: Drivers Lic#:

E-mail: □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time Attends:_____

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

Referred By:

Primary Insurance Information:

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

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip: