Patient Registration

First Name: ___________________________ Last Name: ____________________________ Middle Initial: ____________

How do you wish for us to address you at our office?: ____________________________

Patient Information:

Sex: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: ____

City: _______________________________ State: _____________________ Zip Code: ___________

Home phone: ____________________ Work Phone: _________________ Mobile Phone: _____________

Date of Birth: ______________________ Age: __________ Social Security#: ____________________

Driver's License #: ____________________ State: ___________

Email address: ______________________________ ☐ I would like to receive email correspondence.

Emergency Contact: ___________________________ Relationship to you: ____________________

Phone: ______________________________________ Alternate Phone: ______________________

Responsible Party (if someone other than patient):

Address: ____

City: _______________________________ State: _____________________ Zip Code: ___________

Home phone: ____________________ Work Phone: _________________ Mobile Phone: _____________

Date of Birth: ______________________ Age: __________ Social Security#: ____________________

Driver's License #: ____________________ State: ___________

Email address: ______________________________ ☐ I would like to receive email correspondence.

Primary Dental Insurance Information:

Name of Insured: ________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: ____________________________

Insured Date of Birth : ________________________

Employer: ______________________________

Insurance Company: _______________________

Group Number: _____________________________

Claims Address: P. O. Box #_____________
____
____

Claims Phone Number: ____________________

Secondary Dental Insurance Information:

Name of Insured: ________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: ____________________________

Insured Date of Birth : ________________________

Employer: ______________________________

Insurance Company: _______________________

Group Number: _____________________________

Claims Address: P. O. Box #_____________
____
____

Claims Phone Number: ____________________