PATIENT REGISTRATION

First Name:______________________________ Middle Initial:______ Last Name:_____________________________

Preferred Name:__________________________ Date of Birth:_______________ SS#__________________________

Address:________________________________ City, State, Zip:____

Home Phone:____________________ Mobile:_______________________ Email:____________________________

Work Phone:______________________ Ext:_____________ May we call you at work? ○ Yes ○ No

Would you like to receive messages by email? ○ Yes ○ No / by text message? ○ Yes ○ No

Employer:____ Drivers Lic:______________________

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

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

Emergency Contact:_____________________________________ Phone:_________________________________

Referring Dentist:_______________________________ Reason for Referral:_________________________________

Responsible Party (if other than patient):___________________________ Relationship to Patient: ____________

Address:________________________________ City, State, Zip:____

Home Phone:____________________ Mobile:_______________________ Email:____________________________

Work Phone:______________________ Ext:_____ May we call you at work? ○ Yes ○ No

Employer:____ Drivers Lic:______________________

Primary Dental Insurance Information

Name of Insured:________________________________ Patient Relationship: ○ Self ○ Spouse ○ Child ○ Other

Insured SS# or ID#_______________________________ Insured Date of Birth________________________________

Employer or Group Name:_____________________________________ Group#______________________________

Name of Insurance Company___________________________________ Phone#______________________________

Address:____ City, State, Zip:______________________________

Secondary Dental Insurance Information

Name of Insured:________________________________ Patient Relationship: ○ Self ○ Spouse ○ Child ○ Other

Insured SS# or ID#_______________________________ Insured Date of Birth________________________________

Employer or Group Name:_____________________________________ Group#______________________________

Name of Insurance Company___________________________________ Phone#______________________________

Address:____ City, State, Zip:______________________________