PATIENT REGISTRATION

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

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

Patient Information

Address: Address 2:

City: State / Zip:

Home Phone: Work Phone: Ext: Cellular: _____

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

Birth Date: Age: Soc Sec:

Section 2

Pref. Dentist: E-mail:

Pref. Pharmacy:

☐ I would like to receive correspondences via e-mail.

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: Insured Birth Date:

Insured Soc. Sec:

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

Address:

City, State, Zip:

Secondary Insurance Information

Name of Insured: Insured Birth Date:

Insured Soc. Sec:

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

Address:

City, State, Zip: