

# PATIENT REGISTRATION

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

Patient is:  Responsible Party  Policy Holder

Preferred Name: \_\_\_\_\_

## 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:

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

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

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

Preferred Pharmacy: \_\_\_\_\_ Do you Pre-Medicate? \_\_\_\_\_

Referred By: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Emergency phone number: \_\_\_\_\_

**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: \_\_\_\_\_

**Secondary 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: \_\_\_\_\_