PATIENT REGISTRATION

PATIENT INFORMATION:

First Name:_____ Last Name:_____ Middle:_____

Address: _____ City, State, Zip:_____

Home Phone:_____ Cellular:_____ Work:_____

Email:_____ May we contact you by email or text?_____

Birth Date:_____ Sex: M____ F_____ SS#:_____

Drivers License State & #:_____ Student Status: Full Time Part Time

Marital Status: M S D W Emergency Name & Phone: _____

RESPONSIBLE PARTY (if different from patient):

First Name:_____ Last Name:_____ Middle:_____

Address:_____ City, State, Zip_____

Home Phone:_____ Cellular:_____ Work:_____

Birth Date:_____ SS#_____ Relationship to Patient:_____

Drivers License State & #_____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to Insured_____

Insured SS#_____ Insured Birth Date:_____

Insured Employer:_____ Insurance Company:_____

Insurance Address:_____ City, State, Zip _____

Insurance Phone #:_____ Do you have Secondary Insurance? _____

Previous Dentist: _____ Preferred Pharmacy:_____