

# Patient Registration

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **MI** \_\_\_\_\_

I prefer to be called \_\_\_\_\_ E-Mail address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_/\_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex: Male  Female  Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Student Status:  Full Time  Part time Name of School \_\_\_\_\_

Person responsible for account: Name/Address \_\_\_\_\_

## **Insurance Information**

### **Primary Dental Insurance:**

Name of Policy Holder \_\_\_\_\_

Relationship to patient: Self  Spouse  Child  Other

Policy holder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy holder's birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### **Secondary Dental Insurance:**

Policy holder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy holder's birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_