Patient Registration

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Address: _____ City, State, Zip: _____
Employer: _____ ***Email:*** _____
Home Phone: _____ Work Phone: _____ Ext: _____
Cellular: _____Birth Date: _____
Soc. Sec: _____ Sex: ( ) Male ( ) Female
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Responsible Party (if patient is **under** the **age of 18**)

First Name: _____ Last Name: _____ Middle Initial: _____
Spouse's Name: _____
Address: _____Address 2: _____
City, State, Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Cellular: _____ Birth Date: _____
Soc. Sec: _____ Sex: ( ) Male ( ) Female

Primary Dental Insurance Information

Name of Insured: _____Relationship to Patient: _____
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Address:_____
City,State,Zip: _____Phone: _____
Ins. Company: _____ Address: _____
City,State,Zip: _____ Phone: _____

Secondary Dental Insurance Information

Name of Insured: _____Relationship to Patient: _____
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Address:_____
City, State, Zip: _____ Phone: _____
Ins. Company: _____ Address: _____
City, State, Zip: _____ Phone: _____

Patient Preferences

Pharmacy: _____Pharmacy address or town: _____
Referring Dentist: _____ Dentists phone #: _____