Date: ____________________

Referred By: ____________________

Patient Registration

Patient Information

Name: First ____________________ Mi _______ Last ______________________ Birth Date ________________

Sex: Male Female Social Security #: _________________ Driver's License #: ______________________

Address ________________________________ City, State, Zip: _______________________________________

Home Phone _______________ Work Phone ______________ Cell Phone ______________________________

Email: __________________________________ Employer: ____

Notification Preference: Email ____ Text Message ____

Emergency Contact: _____________________________________ Phone #: ______________________________

Person Responsible for Account

Self ______ Spouse ______ Father ______ Mother _____ Other ______

Name: ____ Birth Date: ___________________________

Social Security #: _________________________ Driver's License: ____________________________________

Address: __________________________________ City, State, Zip: ___________________________________

Home Phone: ______________ Work Phone: ______________________ Cell Phone: ____________________

Primary Dental Ins. Company

Ins. Company: ________________________________ Phone #: ____________________ Group #: ___________

Employer Name: _________________________________ Member ID: _________________________________

Name of Policy Holder ____ Date of Birth: ___ ________________

Social Security #: ___________________ Relationship to Patient: Self ___ Spouse ____ Child ____ Other ____

Address: ________________________________ City, State, Zip: ___________________________________

Phone: ____________________ Work Phone: ___________________ Cell Phone: ______________________

Secondary Dental Ins. Company:

Ins. Company: ________________________________ Phone #: ____________________ Group #: ___________

Employer Name: _________________________________ Member ID: _________________________________

Name of Policy Holder ____ Date of Birth: ___ ________________

Social Security #: ___________________ Relationship to Patient: Self ___ Spouse ____ Child ____ Other ____

Address: ________________________________ City, State, Zip: ___________________________________

Phone: ____________________ Work Phone: ___________________ Cell Phone: ______________________