PATIENT REGISTRATION

First Name: ____________________________ **Last Name:** _______________________ **Middle Initial:** ___

Preferred Name: ___________________________________

Responsible Party (if someone other than the patient)

First Name: _________________________ Last Name: _______________________________ Middle Initial: _______

Address: ____

City, State, Zip: ____

Home Phone: ________________ Work Phone: ________________ Ext: ________ Cellular: ___________________

Birth Date: __________________ Soc Sec: __________________ Drivers Lic: ___________________________

Patient Information

Address: ____

City: ____________________________ State / Zip: ______ _____________

Home Phone : ______________________ Work Phone: ____________________ Cellular: _____________________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated

Birth Date: _________________ Age: __________ Soc. Sec: ________________ Drivers Lic: _________________

E-Mail: ____ ☐ I would like to receive correspondences via e-mail.

Section 2 Employment

Employer: _________________ Position: _______________

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Section 3 Misc.

Referred By: ______________________________

Previous Dentist: ___________________________

Emergency Contact: _______________________

Pharmacy: _______________________________

Primary Insurance Information

Name of Insured: ___________________________________ Relationship to Insured: ○ Self ○ Spouse ○ Child

Insured Soc. Sec: ______________________ Insured Birth Date: ______________________

Employer: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Ins. Company: ___________________________________

Address: ____

City, State, Zip: _________________________________