PATIENT REGISTRATION

Patient Information … Please PRINT clearly. Thank you!

First Name: ___________________ Last: __________________ Middle Initial: ____
Address: ____
City, State, Zip: ____
Home Phone (___) ____ -_____ Work (___) ____ -_____ Cell (____) _____ -_______
Email Address: __________________________ Sex: M /F
Birth Date: _____________ Age: ______ Social Security Number ________________
Marital Status: ______________ Main Dental Concern ________________________
Do you use pre-medication antibiotic prior to dental treatment? Y / N
EMERGENCY CONTACT NAME & CONTACT: _________________________________
How did you hear about our office! ___________________________

Responsible Party (If someone other than patient)

First Name: _________________ Last: __________________ Middle Initial: _____
Address: ____
City, State, Zip: ____
Home Phone (____) ____ -______ Work (___) ____ -_____ Cell (___) ____ -_______
Birth Date: _________________ Social Security Number ________________

- Responsible party is also policy holder for patient
- Primary Insurance holder
- Secondary Insurance holder

Insurance Information (Please provide insurance card)

Name of Insurance Company: ________________________
Name of Policy Holder: ____
Policy holder SSN# __________ Policy Holder Date of Birth: _____________
Policy Holder ID # _________________________ Group ID # __________________
Relationship to patient: ________________________
Name of Policy Holder Employer: ___________________________
City, State of Employer: _____________________