PATIENT REGISTRATION

DATE: ____________________

Patient's Full Legal Name:____ Preferred Name:____________________

SSN:_________________________ Date of Birth:___________________ Gender: ◯Male ◯Female

Address:____ Driver's License#:___________________

City:_________________________ State:_____________ Zip:_________________ Home Phone:_______________________

Cell Phone:________________________

Marital Status: ◯Single ◯Married ◯Divorced/Separated ◯Widowed

Employment: ◯Full-time ◯Part-Time ◯Retired Occupation:_______________ Employer:____________________________

Student Status: ◯Full-time ◯Part-Time School/College:

Emergency Contact:____ Emergency Contact Phone:______________

How were you referred to our office? ◯Insurance ◯Current Patient ◯Mail/Brochure ◯Other

Please specify referral:_________________________________

Name of previous Dentist:____________________________________

Do you require an antibiotic pre-medication for dental appointments? ◯Yes ◯No

What is your general state of health? Excellent_______ Good______ Fair_____ Poor______

Name of current Physician:_______________________________________

Phone number of current Physician:_______________________________

Preferred Pharmacy:___________________________ Pharmacy Phone:______________________________

INSURANCE AND BILLING INFORMATION

RESPONSIBLE PARTY

Person Responsible for this Account:_______________________________ Relationship to Patient:________________

SSN:_________________ Date of Birth:__________________ Gender: ◯Male ◯Female

Address:____ Driver's License#:_____________________

City:________________________ State:______ Zip:_______________ Home Phone:__________________________

Email:____ Cell Phone:__________________________

Is the Responsible Party a Current Patient in Our Office? ◯Yes ◯No Employer:___________________________

If you have dental insurance, we will be happy to assist you in obtaining your benefits and will estimate your benefits based upon your policy information. It is important, however, for you to understand that insurance plans vary greatly so we cannot be certain what benefits your insurance company will pay. Any question over coverage is ultimately the responsibility of your insurance company.

PRIMARY INSURANCE

Name of Policy Holder:____ Relationship to Patient:________________

SSN:_________________ Date of Birth:__________________ Gender: ◯Male ◯Female

Name of Policy Holder's Employer:____ Employer Phone:_____________________

Insurance Company:____ Insurance Phone:_____________________

Policy Holder Member ID#:__________________________________ Group#:______________________________

SECONDARY INSURANCE

Name of Policy Holder:____ Relationship to Patient:________________

SSN:_________________ Date of Birth:__________________ Gender: ◯Male ◯Female

Name of Policy Holder's Employer:____ Employer Phone:_____________________

Insurance Company:____ Insurance Phone:_____________________

Policy Holder Member ID#:__________________________________ Group#:______________________________

To the best of my knowledge, all of the preceding is correct. If I ever have a change in my health, medication, or medical condition, I will inform the dentist at my next appointment. I authorize release of any information to my insurance company and/or other providers involved in my treatment.

Signature:____ Date:_____________________________

02/01/2019