PATIENT REGISTRATION

Today's Date:_____

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is: ☐ **Policy Holder** **Preferred Name:_____**

☐ **Responsible Party**

Patient Information

Address:_____

City:_____ State / Zip:_____

Home Phone:_____ Work Phone:_____ Ext:____ Cell:_____

Sex: ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Birth Date:_____ Age:_____ Soc Sec: _____

Email:_____ ☐ **I would like to receive correspondences via email.**

Responsible Party (If someone other than patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Birth Date:_____ Soc Sec:_____

Primary Dental Insurance Information

Name of Insured:_____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insured Soc. Sec:_____ Insured Birth Date:_____

Ins. Company:_____ **Employer:_____**

Address:_____ **Group Number:_____**

City, State, Zip:_____ **ID Number:_____**

Secondary Dental Insurance Information

Name of Insured:_____

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insured Soc. Sec:_____ Insured Birth Date:_____

Ins. Company:_____ **Employer:_____**

Address:_____ **Group Number:_____**

City, State, Zip:_____ **ID Number:_____**