

## PATIENT REGISTRATION

Whom may we thank for referring you to us? \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name : \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient is :  Responsible Party Preferred Name: \_\_\_\_\_  
 Policy Holder

### Responsible Party: (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  I would like to use texting as a mode of communication.

E-mail \_\_\_\_\_  I would like to receive email communication

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

Responsible Party is Policy Holder for Patient  Primary Policy Holder  Secondary Policy Holder

### Patient Information:

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  I would like to use texting as a mode of communication.

E-mail: \_\_\_\_\_  I would like to receive email correspondences

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

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

### Patient Information (section 2):

Employment Status:  Full Time  Part Time  Self Employed  Retired  Unemployed

Preferred Dentist: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

### Primary Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Employer ID: \_\_\_\_\_ Carrier ID: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Birth date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### Secondary Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Employer ID: \_\_\_\_\_ Carrier ID: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Birth date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_