PATIENT REGISTRATION

First Name_____ Last Name_____ Middle Initial_____

Preferred Name_____

Patient Information

Address_____ Address 2_____

City, State,Zip_____ Email_____

Home Phone _____Work Phone _____ Ext._____ Cell Phone_____

Sex: ☐Male ☐Female **Martial Status:** ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Birth Date _____ Age _____ Soc. Sec. #_____ Drivers Lic.#_____

How did you hear about us? _____ When was your last dental visit?_ _____

Responsible Party (*if patient is a minor***)**

First Name_____ Last Name_____ Middle Initial_____

Address_____ Address 2_____

City, State,Zip_____ Email_____

Home Phone _____Work Phone _____ Ext._____ Cell Phone_____

Birth Date_____ Age_____ Soc. Sec. #_____ Drivers Lic.#_____

Section 2

Employment Status: ☐Full Time ☐Part Time ☐Retired

Student Status: ☐Full Time ☐Part Time

Section 3

Guardian Name_____

Guardian Phone_____

Primary Insurance Information

Name of Insured _____ Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec. # _____ Insured Birth Date _____

Employer _____ Insurance Company_____

Address_____ Address_____

City, State, Zip _____ City, State, Zip _____

Secondary Insurance Information

Name of Insured_____ Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec. # _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____