PATIENT REGISTRATION

First Name _____ Last Name _____ Middle Initial _____
Patient is: ___ Policy Holder Preferred Name _____
___ Responsible Party

Patient Information
Address _____ Address 2_____
City, State, Zip:_____ Pager _____
Home Phone _____ Work Phone _____Ext_____ Cellular:_____
Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Birth Date _____ Age_____ Soc Sec._____ Driver's Lic:_____
E-mail _____ □ I would like to receive correspondence via e-mail

Employment Status □ Full Time □Part Time □ Retired
Student Status: □Full Time □Part Time
Preferred Dentist:_____
Preferred Pharmacy:_____
Preferred Hygienist:_____

Referred By _____
□Patient □Phone Book
□Website □Family
□Friend □Other

Responsible Party (if someone other than the patient)
First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2_____
City, State, Zip:_____ Pager _____
Home Phone _____ Work Phone _____Ext_____ Cellular:_____
Birth Date _____ Soc Sec._____ Driver's Lic:_____
□Responsible Party is also a Policy Holder □Primary Insurance Holder □Secondary Insurance Policy Holder

Primary Insurance Information
Name of Insured:_____ Relationship to Insured □Self □Spouse □Child □Other
Insured Soc Sec:_____ Insured Birth Date:_____ Group # _____
Employer: _____ | Ins. Company:_____
Address:_____ | Address _____
Address 2:_____ | Address 2_____
City, State, Zip: _____ | City, State Zip:_____
Rem. Benefits _____.00 Rem. Deduct._____.00

Secondary Insurance Information
Name of Insured:_____ Relationship to Insured □Self □Spouse □Child □Other
Insured Soc Sec:_____ Insured Birth Date:_____ Group # _____
Employer: _____ | Ins. Company:_____
Address:_____ | Address _____
Address 2:_____ | Address 2_____
City, State, Zip: _____ | City, State Zip:_____