PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ M: _____

Preferred Name (What would you like us to call you?): _____

Address: _____ Apt #: _____

City: _____State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

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

Birth Date: _____ Social Security #: _____ Drivers Lic. # & State: _____

Primary Language Spoken: _____ Is Translator needed for appointments?: YES NO

Email: _____ (Parent Email if minor)

(Email is used for reminders, appointment confirmations and newsletters/promotions)

How did you hear about our office? _____

PRIMARY DENTAL INSURANCE INFORMATION:

Subscriber's First Name: _____ Last Name: _____ M: _____

Subscriber's Birth Date: _____ Subscriber's Social Security #: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Employer (if group policy): _____ Group #_____ Patient ID: _____

Insurance Co. Name: _____ Phone # _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

*** Please advise us if you have secondary dental insurance****

PARENT INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR):

Mother's Name: First Name: _____ Last Name: _____ M: _____

Birth Date: _____ Social Security #: _____ Drivers Lic # & State: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Father's Name: First Name: _____ Last Name: _____ M: _____

Birth Date: _____ Social Security #: _____ Drivers Lic # & State: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Child Lives With: □ Both Parents □ Mother □ Father □ Other _____

Responsible Party: □ Mother □ Father □ Other _____