PATIENT REGISTRATION FORM

❖ **Patient Information** **Please *Print* clearly.**

First name: _____ Last name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home phone: (____) _____-_____ Work phone: (____) _____-_____ Cell: (____) _____-_____

Birth Date: _____ Age: _____ Soc Sec: _____

Sex: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer: _____ City, State:_____

Student Status: □ Full Time □ Part Time Name of School: _____

Email Address: _____

Preferred Pharmacy: _____

✓ Main Dental Concern:_____

Do you use a pre-medication prior to dental treatment (anti-biotic)? _____

How were you referred to our office? (Referral Source)_____

EMERGENCY CONTACT: _____ Phone: (___) _____-_____

INSURANCE

- ○ Responsible party is also the Policy Holder for Patient
- ○ Primary Insurance Holder
- ○ Secondary Insurance Holder
- ○ **Responsible Party (if someone other than patient)** □ **Check here if same as above**

First name: _____ Last name: _____ Middle Initial: _____
Address:_____
City, State, Zip:_____

❖ **Insurance Information (please provide insurance card)**

Name of Insured::_____ Relationship to Insured: ○ Self ○ Spouse ○ Child
Insured Soc. Sec: _____ Insurance Company: _____
Address: _____ City, State, Zip: _____
Group Number: _____ Identification Number: _____

❖ **Secondary Insurance Information (please provide insurance card)**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child
Insured Soc. Sec: _____ Insurance Company: _____
Address: _____ City, State, Zip: _____
Group Number: _____ Identification Number: _____