

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Birth Date: _____ Home Phone: _____ Work Phone: _____ Cellular: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

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

Birth Date: _____ Age: _____ E-mail: _____

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Prof. Pharmacy: _____

Section 3

Referred By _____
Previous Dentist _____
Emergency Contact _____
Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured ID: _____ Insured Birth Date: _____

Employer: _____ Ins. 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

Insured ID: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

General Questions

When was your last visit to a dentist? _____

Who was your previous dentist? _____

Is there anything you would like to talk with the dentist about? _____

Are you in any pain or discomfort? _____

How did you hear about us? _____

We are a family practice - Will any other family members be joining the practice? (Name/DOB) _____