

Patient Registration

Patient Information

Whom may we thank for referring you to our office? _____ Date _____

Patient Name _____ Age _____ Birthdate ____/____/____ M or F
First M.I. Last (Circle)

Residence & Mailing Address _____
Street Po Box City State Zip

Social Security No. _____ U.S. Citizen? Yes No

Phone Numbers:
Home: _____

Employer _____ Occupation _____
Cell: _____

Work: _____ Ext: _____

Years Employed _____ Driver's License No. _____ State _____
Email: _____

Responsible Party Information

Please complete this section if someone other than patient will be paying the bill.

Responsible Person _____ Age _____ Birthdate ____/____/____ M or F
First M.I. Last (Circle)

Residence & Mailing Address _____
Street PO Box City State Zip

Relationship to Patient _____ Drivers License No. _____

Phone Numbers:
Home: _____

Employer _____ Occupation _____
Cell: _____

Work: _____ Ext: _____

Years Employed: _____ Social Security No. _____
Email: _____

Spouse Information

Spouse Name _____ Employer _____ Work # _____ Ext: _____

Social Security No. _____ Drivers License No. _____ State _____ Birthdate: _____

Dental Insurance Information

Primary Insurance _____
Policy Holder Birthdate ID# Grp#

Insurance Company _____
Name of Insurance Address Phone number

Secondary Insurance _____
Policy Holder Birthdate ID# Grp#

Insurance Company _____
Name of Insurance Address Phone Number

Person to contact if unable to reach you directly

Name of Friend or Relative (not living with you) _____
First M.I. Last Relationship

Residence & Mailing Address _____
Street PO Box City State Zip

Home Phone # _____ Cell Phone # _____

I certify that I am authorized to furnish the above information requested. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay to the dentist all benefits and authorize this signature on all insurance submissions.

Signature: _____ **Date:** _____