# Patient Registration

First Name: ________________ Last Name: ___________________ Preferred Name:______________

Referred By: ___________________________________________________________________________

Address: _______________________________________________________________________________

City, State, Zip:_______________________________________________________________________

Home Phone Number: ______________________ Cell Phone Number: _________________________

Birth Date: _____________________ Social Security Number: _______________________________

Email Address: _________________________________________________________________________

**<u>Primary Dental Insurance Information:</u>**

Name of Subscriber: ____________________________________________________________________

Subscriber Birth Date: ______________Subscriber Social Security Number: _____________________

Subscriber Employer: ___________________________________________________________________

Dental Insurance Company: _______________________________________________________________

Insurance Company Address: ______________________________________________________________

City, State, Zip: _____________________________________________________________________

**<u>Primary Medical Insurance Information:</u>**

Name of Subscriber: ____________________________________________________________________

Subscriber Birth Date: ________________Subscriber Social Security Number: ___________________

Medical Insurance Company: ______________________________________________________________

Medical Insurance Company Phone Number: ______________________________________________

ID Number: _____________________________ Group Number: ______________________________

*To maximize your health benefits please provide a copy of both your DENTAL and MEDICAL insurance cards to the front office.*

EMERGENCY CONTACT: __________________________ Phone Number: ____________________