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PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Patient is: Policy Holder Responsible Party Preferred Name:

PATIENT INFORMATION

Address: City: State: Zip:
Address 2: City: State: Zip:
Home Phone: Work Phone: Ext: Cell:
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: SS #: Driver's Lic.:

Section 2

Section 3

In an effort to go "green" our office is trying to minimize paper usage.
If you would like us to e-mail your confirmations, appointment reminders, etc. please provide your e-mail in the space below.
E-mail:

Referred By:
Previous Dentist:
Emergency Contact:
Emergency Contact #:

HIPPA RELEASE

Dental information may be released or shared with the following individual(s):

RESPONSIBLE PARTY (If other than patient)

First Name: Last Name: Middle Initial:
Address: City: State: Zip:
Address 2: City: State: Zip:
Home Phone: Work Phone: Ext: Cell:
Birth Date: SS #: Driver's Lic.:

PRIMARY INSURANCE INFORMATION

Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured SS#: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City: State: Zip: City: State: Zip: