PATIENT REGISTRATION

Patient First Name:____________________ Patient Last Name:________________________

Patient Is: O Policy Holder
O Responsible Party for Account

Responsible Party Information (if someone other than the patient):

First Name:__________________ Last Name:______________________________
Street Address:______________________ City:__________ State:______ Zip:________
Home Phone:(   )____________ Work Phone:(   )____________ Ext:________
Cell. Phone:(   )____________ Date of Birth:________ SS#:______________
Sex: O Male O Female Employment Status: O Full Time O Part Time O Retired
Marital Status: O Married O Single O Divorced O Seperated O Widowed

Patient Information:

Street Address:______________________ City:__________ State:______ Zip:________
Home Phone:(   )____________ Work Phone:(   )____________ Ext:________
Cell. Phone:(   )____________ Date of Birth:________ SS#:______________
Sex: O Male O Female Employment Status: O Full Time O Part Time O Retired
Marital Status: O Married O Single O Divorced O Seperated O Widowed
Student Status: O Full Time O Part Time

How did you hear about us?

O Phonebook O Signs O Family Member-Who?____________________
O Friend-Who?__________________ O Co-Worker-Who?____________________
O Other:________________________________

Insurance Information:

-Primary Dental Insurance Company:______________________________________
Address:______________________ City:__________ State:______ Zip:________
Insured's Name:____________________________ Date of Birth:____________
Group #:___________ SS#______________ Employer:____________________
Relationship to Patient: O Self O Spouse O Child O Other
-Secondary Dental Insurance Company:______________________________________
Address:______________________ City:__________ State:______ Zip:________
Insured's Name:____________________________ Date of Birth:____________
Group #:___________ SS#:______________ Employer:____________________
Relationship to Patient: O Self O Spouse O Child O Other