PATIENT REGISTRATION

Patient Information **Please PRINT clearly. Thank you.**

First name: ______________________________Last name: ______________________________________Middle Initial: ________

Address: ____Apt. Number :_____________

City:____ State:____________ Zip: ____________

Home phone :(______) _______-____________ Cell: (______) _______-__________ Work:(______) _______-__________

Other:(______) _______-__________ Would you like to receive text messages regarding appointments? _________

Email address:____

Birth Date: ____________________________________ Age: _______ SSN: ___________________________

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

Name of Spouse:______________________________ Spouse's birth date:__________________ SSN:______________________

Employment Status: □ Full Time □ Part Time □ Retired Spouse's Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer:_____________________________ City, State: _________________________

Name of Spouse's Employer:_____________________________ City, State: _________________________

Student Status: □ Full Time □ Part Time Name of School_______________________________ City, State: ________________

Preferred Pharmacy:____

Physicians Name:____Phone:____________________________________

How did you find our office? (Referral Source)____

EMERGENCY CONTACT ____ Phone:(______) _______-___________

Responsible Party (if you are filling this out for your child please complete this area)

First name: ______________________________Last name: ____________________________________Middle Initial: ________

Address: ____Apt. Number :_____________

City:____ State:____________ Zip: ____________

Home phone :(______) _______-____________ Cell: (______) _______-__________ Work: (______) _______-___________

Birth Date:_______________________ SSN: ________________________ Relationship to Patient:___________________

□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Primary Dental Insurance:

Insurance Company name:_______________________________________ Phone number:___________________________

Name of Policy Holder:____ Policy Holder Birth Date:___________________

Policy Holder's Employer:____ Group # (Plan, local or policy #):______________

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder ID **#**:_________________________________

Secondary Dental Insurance:

Insurance Company name:_______________________________________ Phone number:___________________________

Name of Policy Holder:____ Policy Holder Birth Date:___________________

Policy Holder's Employer:____ Group # (Plan, local or policy #):______________

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder ID **#**:_________________________________

Assignment of Benefits:

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the provider for services rendered.

Subscriber Signature:____