# REGISTRATION FORM

## PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

DOB: _____ Sex: □ M □ F SS#: _____

Mailing Address: _____
Street Name/# City State Zip Code

Home Phone#: _____ Cell#: _____

## RESPONSIBLE PARTY (if someone other than patient)

First Name: _____ Last Name: _____ MI: _____

DOB: _____ Sex: □ M □ F SS#: _____(required)*

Mailing Address: _____
Street Name/# City State Zip Code

Home Phone#: _____ Cell#: _____

Email: _____ Marital Status: □ Single □ Married □ Divorced □ Other

Relationship to patient: _____ ***If SS# is not provided, patient will be responsible for filing dental claims**

## PRIMARY DENTAL BENEFIT PLAN

Policy Holder Name: _____ DOB: _____

SS#: _____ Relationship to patient: _____

Employer: _____

Dental Benefit Plan Name: _____

Phone #: _____ ID#: _____

Group#: _____

## SECONDARY DENTAL BENEFIT PLAN

Policy Holder Name: _____ DOB: _____

SS#: _____ Relationship to patient: _____

Employer: _____

Dental Benefit Plan Name: _____

Phone #: _____ ID#: _____

Group#: _____