PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ ☐ I would like to receive correspondences via text

Birth Date: _____ Soc. Sec. #: _____ Sex: ☐ Male ☐ Female

Email: _____ ☐ I would like to receive correspondences via email

Person to contact in case of emergency: _____ Phone: _____

When was your last dental visit? _____

When were your last dental X-Rays? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec. #: _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec. #: _____ Insured Birth Date: _____

Address of Insured: _____

City, State, Zip: _____

Employer: _____ Date Employed: _____

Insurance Company: _____

Group #: _____ ID #: _____

Patient/Guardian Signature: _____ Date: _____