Patient Registration Information

Date ______________________

Name ____
Last First M Preferred

Address ____________________________________ City ______________ State ___ Zip ___________

E-Mail ____________________________________ Birthdate _________________________________

Home Phone ____________________ Work Phone _________________ Cell Phone _________________

How would you like for us to contact you? ❑ Phone ❑ Text ❑ Email

Drivers License #___________________________ Social Security # ______________________________

Are You: ❑ Minor ❑ Single ❑ Married ❑ Other ____________________________________
❑ Male ❑ Female

Employer (Parent's employer if minor) _____________________________Work Phone _____________

Occupation ________________________Spouse's name (Parent's name if minor) ______________________

Spouse's Birthdate _________________________________ Work Phone __________________________

Emergency contact other than spouse or parent ___________________________Phone _______________

Whom may we thank for referring you? ____

What did you like or dislike about your previous dental office? ____________________________________

Responsible Party

_____ **Check if same as above**

Person responsible for this account _________________________________Relationship_______________

Address ____ Home Phone ________________

City, State, Zip ____

Insurance Information

Name of policyholder____

Relationship to patient ____

Birthdate _________________Insurance ID #____________________SSN:__________________________

Address if different from above ____

Insurance Company ______________________________ Phone #_________________________________

Do you have additional insurance? ❑ Yes ❑ No If yes, complete the following:

Name of policyholder____

Relationship to patient ____

Birthdate _________________ Insurance ID # ___________________ SSN: _________________________

Address if different from above ____

Insurance Company ______________________________ Phone # _________________________________