Patient Registration

Date Click or tap to enter a date.

First Name: **Last Name:** **MI:**

I prefer to be called (nickname) E-Mail address

Address

City/ State/Zip

Home phone Cell

Work Phone Preferred contact phone number

Birthdate Age ☐ Female ☐ Male

Social Security Driver's License number

Who may we thank for referring you?

Why have you come to the dentist today?

Employer Occupation

Student Status: ☐ Full time ☐ Part time Name of School

Person responsible for account:

Address Phone Number

Closest Emergency Contact Not living with you:

Address Phone Number

Insurance Information

Primary Dental Insurance:

Name of Policy Holder

Relationship to patient: ☐ Self ☐ Spouse ☐ Child Policy holder's ID #

Policy holder's birthdate Group #

Employer Insurance Company

Address Address

City, State, Zip City, State, Zip

Secondary Dental Insurance:

Name of Policy Holder

Relationship to patient: ☐ Self ☐ Spouse ☐ Child Policy holder's birthdate

Policy holder's ID # Group #

Employer Insurance Company

Address Address

City, State, Zip City, State, Zip