PATIENT REGISTRATION

PLEASE PRINT

First Name: ______________________ **Last Name**: ______________________ **Middle Initial**: ______

Address: ____ **Apt/Suite**: ________

City, State, Zip: ______________________ ____ ______ **Home Phone**: __________________

Work Phone: ______________________ **Ext.** _______ **Cell Phone**: __________________

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Married ☐ Single ☐ Domestic Partner ☐ Widowed

Birth Date: ___/___/_____ **Social Security#:** ____________________ **DL#:** __________________

Email: ____ ☐ I would like to receive correspondences via e-mail

Employer: ____ **Occupation:** __________________________

In case of emergency, please contact:

Referred by: ___________________________________ **Name**: ____________________________________

Phone: _______________ **Relationship** ________

PARENT/LEGAL GUARDIAN OF MINORS OR MEDICAL DIRECTIVE/POWER OF ATTORNEY INFORMATION ONLY

First Name: ______________________ **Last Name**: ______________________ **Middle Initial**: ______

Address: ____ **Apt/Suite**: ________

City, State, Zip: ______________________ ____ ______ **Home Phone**: __________________

Work Phone: ______________________ **Ext.** _______ **Cell Phone**: __________________

Birth Date: ___/___/_____ **Social Security#:** ____________________ **DL#:** __________________

☐ Responsible party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Employed by: ____ **Occupation**: __________________________

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DENTAL INSURANCE ONLY - PRIMARY (NO MEDICAL)

Policy Holders Name: ___________________________________ **DOB**: _____/_____/_______

Social Security: ____ **ID#**: ________________________

Policy Holders Address ____
(If different from above)

Dental Insurance Co. Name: ______________________________ **Dental Phone #**: ________________

Employed by: ____ **Occupation**: ____________________

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DENTAL INSURANCE ONLY - SECONDARY (NO MEDICAL)

Policy Holders Name: ___________________________________ **DOB**: _____/_____/_______

Social Security: ____ **ID#**: ________________________

Policy Holders Address ____
(If different from above)

Dental Insurance Co. Name: ______________________________ **Dental Phone #**: ________________

Employed by: ____ **Occupation**: ____________________