

# 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: \_\_\_\_\_

Referred by: \_\_\_\_\_ In case of emergency, please contact:

Name: \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

**\* 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: \_\_\_\_\_

**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 #: \_\_\_\_\_

**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: \_\_\_\_\_