Patient Registration

First Name:_____ Last Name:_____ Middle Initial:____
Patient is: □ Policy holder Preferred Name:_____
□ Responsible party

Responsible party (if someone other than patient)
First name:_____ Last Name:_____ Middle Initial:_____
Address:_____ Address 2: _____
City, State, and Zip: _____
Home Phone: _____ Work Phone:_____ Cellular: _____
Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

□Responsible party is also a policy holder for patient □Has primary insurance □Secondary insurance policy holder

Patient Information
Address:_____ Address 2: _____
City:_____ State: _____ Zip: _____
Home Phone: _____ Work Phone:_____ Cellular: _____
Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
Sex: _____ Marital Status: _____
Email: _____ □ I would like to receive correspondences via e-mail

Employment Status: □Full Time □Part Time □Retired
Student Status: □Full Time □Part Time

Pref. Pharmacy:_____
Pref. Hygienist.: _____

Emergency phone: _____
Prior Dental problem:_____
previous perio tx: _____
Currently in pain?: _____
Do you take Pre-Med?: _____
Referred By: _____
Last Cleaning: _____

Primary Dental Insurance Information: DENTAL ONLY, NOT MEDICAL
Name of the policy holder/primary insured person: _____
MemberID#:_____ Group ID: _____
Relationship to the policy holder/insured:__ _____
Insured Social Sec: _____ Insured birth date: _____
Employer: _____
Insurance Company:_____
Insurance Company Address:_____
City, State and Zip: _____
Phone:_____

Secondary Dental Insurance Information: DENTAL ONLY, NOT MEDICAL
Name of the policy holder/primary insured person: _____
MemberID#:_____ Group ID: _____
Relationship to the policy holder/insured:__ _____
Insured Social Sec: _____ Insured birth date: _____
Employer: _____
Insurance Company:_____
Insurance Company Address:_____
City, State and Zip: _____
Phone:_____