

PATIENT REGISTRATION

Date: _____
Name: _____ Sex: Male _____ Female _____
I prefer to be called: _____
Birthday: ____/____/____ Age: ____ Soc. Sec: _____ Drivers Lic: _____
Please check: Single _____ Married _____ Divorced _____ Widowed _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____
When and where are the best times to reach you? _____ E-mail: _____
Home Address: _____ City: _____ Zip: _____
Employment Status: Full Time _____ Part Time _____ Retired _____
Student Status: Full Time _____ Part Time _____

Employer: _____ How long there? _____ Position: _____
Business Address: _____
Person responsible for account: _____
Spouse's Name: _____ Soc. Sec: _____
Spouse's Employer: _____ Phone: _____ How long there? _____
Name of person to notify in case of an emergency: _____
Relationship: _____ Home Phone: _____ Work Phone: _____
Physician's Name: _____ Phone: _____
Last Dental Visit: _____ Location: _____
Address: _____ Phone: _____
Any dental problems we should be aware of? _____
Who may we thank for referring you to us? _____

PRIMARY INSURANCE

Insurance Co. Name: _____
Address: _____
Phone: _____
Group #: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthday: _____
Policy Owner's S.S. #: _____
Policy Owner's Employer: _____

SECONDARY INSURANCE

Insurance Co. Name: _____
Address: _____
Phone: _____
Group #: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthday: _____
Policy Owner's S.S. #: _____
Policy Owner's Employer: _____