Patient Registration

Patient Information

Today's Date: _____

First Name: _____ Last Name: _____ Mid Int.____

Preferred Name / Nick Name : _____

Address: _____ Apt #: _____
City, State, Zip: _____ Pager: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Birth Date: ____/_____/_____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed
Employer: _____ Occupation: _____
How did you hear about our office?: _____
In the event of an emergency whom should we contact?: Name: _____ Phone #:_____ Relationship: _____
Name of your previous dentist: _____ Date of your last dental visit: _____
Email Address: _____
Do you require pre-medication prior to your dental visit?: ❍ Yes ❍ No For What Reason?: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Preferred Name: _____
Address: _____ Apt #: _____
City, State, Zip: _____ Pager: _____
Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone: (____)_____
Birth Date: ____/_____/_____ Soc. Sec: _____ Drivers Lic:_____
Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed
Employer: _____ Occupation: _____

Primary Dental Insurance

Name of Insured: _____ Relationship to patient: ❍ Self ❍ Spouse ❍ Child ❍ Other
Insured Soc. Sec: _____ Insured's Birth Date: _____
Insured's Employer: _____
Name of Insurance Co. _____
Address of Insurance Co. _____ City, State, Zip: _____
Group #: _____ Contract # (if different than Soc.): _____

Secondary Insurance Information

Name of Insured: _____ Relationship to patient: ❍ Self ❍ Spouse ❍ Child ❍ Other
Insured Soc. Sec: _____ Insured's Birth Date: _____
Insured's Employer: _____
Name of Insurance Co. _____
Address of Insurance Co. _____ City, State, Zip: _____
Group #: _____ Contract # (if different than Soc.): _____