



# PATIENT REGISTRATION

## Patient Information

Check:  Mr.  Mrs.  Ms.  Dr.  Rev Sex:  Male  Female

Patient's Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Last Middle

Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

HmTel: (\_\_\_\_) \_\_\_\_\_ WkTel: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Personal Physician \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you?  Family Dentist  Other \_\_\_\_\_  No Referral

Person Responsible for Account/Payment \_\_\_\_\_ Same Address? Yes  No

## Dental Insurance Information

Name of Insured \_\_\_\_\_  Male  Female

Relationship to Patient:  Self  Spouse  Parent  Other

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Ins. Group No. \_\_\_\_\_ Insurance Co. Phone (\_\_\_\_) \_\_\_\_\_

Please inform us if you have *secondary insurance coverage*.

**Method Of Payment**  Cash  Check  Credit Card  Other \_\_\_\_\_

## Comments

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

