PATIENT REGISTRATION

WHOM MAY WE THANK FOR REFERRING YOU:_____

PATIENT INFORMATION:

FIRST NAME:_____**LAST NAME:**_____**MIDDLE INITIAL:**_____

ADDRESS:_____**ADDRESS 2:**_____

CITY,STATE.ZIP_____**HOME PH:**_____ **CELL:**_____

BIRTH DATE:_____**AGE:**_____**SOC SEC:**_____**DRIVERS LICENSE**_____

SEX: ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐ **MARRIED** ☐ **SINGLE** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **WIDOWED**

E-MAIL:_____ ☐**I WOULD LIKE TO RECEIVE CORRESPONDANCE VIA E-MAIL.**

EMPLOYMENT STATUS: ☐ **FULL TIME** ☐ **PART TIME** ☐ **RETIRED** **STUDENT:** ☐ **FULL TIME** ☐ **PART TIME**

PREVIOUS DENTIST:_____**EMERGENCY CONTACT:**_____**EMERGENCY CON#**_____

RESPONSIBLE PARTY: (IF DIFFERENT FROM PATIENT):

FIRST NAME:_____**LAST NAME:**_____**MIDDLE INITIAL:**_____

ADDRESS:_____**ADDRESS 2:**_____

CITY,STATE.ZIP_____**HOME PH:**_____ **CELL:**_____

BIRTH DATE:_____**SOC SEC:**_____**DRIVERS LICENSE**_____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURED:_____ **RELATIONSHIP** ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER**

INSURED SOC SEC:_____**INSURED DATE OF BIRTH:**_____

INSURANCE COMPANY:_____**EMPLOYER:**_____**GROUP#**_____

ADDRESS:_____**EMPLOYER ADDRESS:**_____

CITY, STATE, ZIP:_____ **CITY, STATE, ZIP:**_____

SIGNITURE FOR RELEASE OF BENEFITS:_____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURED:_____ **RELATIONSHIP** ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER**

INSURED SOC SEC:_____**INSURED DATE OF BIRTH:**_____

INSURANCE COMPANY:_____**EMPLOYER:**_____**GROUP#**_____

ADDRESS:_____**EMPLOYER ADDRESS:**_____

CITY, STATE, ZIP:_____ **CITY, STATE, ZIP:**_____

SIGNITURE FOR RELEASE OF BENEFITS:_____