Patient Registration Form

PATIENT INFORMATION

Last Name _____ First Name _____Middle name _____

Street Address _____ City_____ State _____ Zip _____

Best Phone Number to Reach (_____) _____-_____ Secondary Phone (_____) _____-_____

Email _____ Best Time to Contact _____

Birthday ____/____/_____ Age _____ Social Security # _____-_____-_____ Male__ Female __ Single __ Married__

Employer _____ City _____ State _____ ZIP _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____ ZIP _____

Phone Number (____) _____-_____ Email _____ Birth Date _____/_____/_____

Relationship to Patient: Self ___ Spouse ___ Parent ____ Partner ___ Grandparent ___ Other _____

Social Security Number _____-_____-_____ Occupation _____

Employer _____ Employer Address_____

City _____ State _____ ZIP _____ Work Phone Number (_____) _____-_____

INSURANCE INFORMATION

Primary Insurance Company _____ Employer Name _____

Group Number _____ Insured's Name_____ Relation to Patient

_____

Insured's Birthdate ____/____/_____ Insured's SSN ____-____-_____ Insured's ID Number _____

_____

_____

Secondary Insurance Company _____ Employer Name_____

Group Number _____ Insured's Name _____ Relation to Patient _____

Insured's Birthdate ____/____/_____ Insured's SSN ____-____-_____ Insured's ID Number _____

PERSON TO CONTACT FOR EMERGENCY

Name _____ Home Phone (_____) _____-_____ Cell Phone (_____) ____-_____

Address _____ City _____ State _____ ZIP _____

How did you hear about our dental office?
_____

Patient Signature _____ Date _____

Responsible Party Signature _____ Date _____