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Patient Registration Form

Patient Information

Date _____ Soc. Security # _____

Name _____
First Middle Last

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

☐ Divorced ☐ Widowed ☐ Seperated

Occupation _____

Employer / School _____

Employer Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Phone # _____

Spouse's Employer _____

How did you hear about our office? _____

How did you find our phone number? _____

Contact Information

Home # _____

Work # _____

Cell # _____

Email _____

How do you prefer to be contacted?

☐ Home Telephone
☐ Work Telephone
☐ Cell Phone

In Case of Emergency, whom may we contact?

Name: _____

Relationship _____

Home # _____

Work # _____

Cell # _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____

Address (if different from above) _____

Home phone _____ Cell # _____ email _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Employer Name _____ Employer Phone _____

Ins. Co Name _____ Group # _____ Policy # _____

Ins. Co Add _____ Ins. Co Phone _____

Subscriber Birthdate _____ Subscriber SSN: _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of Insured _____ Relationship to patient _____

Employer Name _____ Employer Phone _____

Ins. Co Name _____ Group # _____ Policy # _____

Ins. Co Add _____ Ins. Co Phone _____

Subscriber Birthdate _____ Subscriber SSN: _____