PATIENT REGISTRATION

Patient's Name____
Spouse / Parent ____
Referred By ____
Date of Birth_____________ **Social Security #**_____________________________
Sex______ **Single**_____ **Married**_____**Widowed**______
Address____

Home #__________________ **Work #**__________________ **Cell #**___________________
E-MAIL Address____

Patient's Employer____
Address____
Occupation____
Full Time Student?_____ **Name of College**____
College City & State____

BILLING INFORMATION

Person Responsible for Payment____
Address & Telephone**- IF DIFFERENT FROM ABOVE**____________________________

Employer Name & Address **IF DIFFERENT FROM ABOVE**___________________________

Work Phone Number **IF DIFFERENT FROM ABOVE** _________________________
Do you have Dental Insurance? ______

____ ________________
SIGNATURE OF RESPONSIBLE PARTY **DATE**

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured________________________________ **Date of Birth**___________________
Address **(IF DIFFERENT)**____
Employer Name & Address **(IF DIFFERENT FROM ABOVE)**_____________________

Patient's Relationship to the Insured? Self, Husband, Wife, Child, Other

Insurance Name____
Insurance Address____

Insurance ID #___________________ **Policy/Group #**_________________

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured_______________________________ **Date of Birth**___________________
Address **(IF DIFFERENT)**____
Employer Name & Address **(IF DIFFERENT FROM ABOVE)**_____________________

Patient's Relationship to the Insured? Self, Husband, Wife, Child, Other

Insurance Name____
Insurance Address____

Insurance ID #____________________ **Policy/Group #**__________________