Patient Registration

First Name: _____ Last Name: _____ Middle Int: _____
Patient is: ☐Policy Holder ☐Responsible Party Preferred Name: _____

Responsible Party

First Name: _____ Last Name: _____ Middle Int: _____
Address: _____ Address 2: _____
City, State, Zip Code: _____ Pager#: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth Date: _____ Soc Sec #: _____ Drivers Lic : _____
☐Responsible Party is also a Policy Holder for Patient ☐Primary Insurance Policy Holder ☐Secondary Insurance Policy Holder

Patient Info

First Name: _____ Last Name: _____ Pager #: _____
Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: ☐Male ☐Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: Age Soc Sec Drivers Lic #
E-Mail Address: _____ ☐I would like to receive correspondences via e-mail

Employment Info

Employment Status: ☐ Full time ☐ Part time ☐ Retired
Student Status: ☐ Full time ☐ Part time
Medicaid ID
Employer ID
Carrier Id

Do you have a fear of dentistry? _____
Are you interested in sedation? _____
Are you interested in Nitrous (laughing gas) _____

Primary Insurance Information

Name of insured: _____ Relationship to insured ☐Self ☐ Spouse ☐Child ☐ Other
Insured Soc. Sec: _____ Insured Date of Birth _____
Employer: _____ Ins Company: _____
Address: _____ Address: _____
Address 2 _____ Address 2: _____
City, State Zip _____ City, State, Zip _____
Rem Benefits _____ Rem. Deduct: _____