PATIENT REGISTRATION

Today's Date

Welcome! How did you find out about our practice?

PATIENT'S DETAILS

First Name:

Last Name:

Middle Name:

Preferred Name:

Gender:

☐ Male ☐ Female

Birth Date:

Address:

City:

State:

Zip:

Home Phone:

Mobile Phone:

Work Phone:

Social Security No.:

Email Address:

Employer:

Occupation:

Name of Emergency Contact:

Emergency Contact Phone:

Relationship of Emergency Contact:

Marital Status:

☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Preferred Contact Method:

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Text Message

PARENT/PARTNER/SPOUSE/GUARDIAN (circle one)

Full Name:

Address (if different than patient):

City:

State:

Zip:

Home Phone:

Mobile Phone:

Work Phone:

Extension:

Employer:

Employer City:

Occupation:

Form continued on reverse

PRIMARY INSURANCE

Policy Holder Name:

Dental Insurance Company:

Insurance Company Phone:

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Address:

Policy Holder Phone:

Group Number:

Policy Holder SS#:

Policy Holder ID#:

Policy Holder DOB:

SECONDARY INSURANCE (if applicable)

Policy Holder Name:

Dental Insurance Company:

Insurance Company Phone:

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Address:

Policy Holder Phone:

Group Number:

Policy Holder SS#:

Policy Holder ID#:

Policy Holder DOB:

OPTIONAL

In order to help us get to know you better, please answer the following questions.

How long have you lived in the area? ______________________________

Where have you lived previously? ______________________________

Do you have any hobbies, special interests or skills? ______________________________

____

Have you taken any interesting vacations or trips? ______________________________

____

Are you currently employed? Where? Position? ______________________________

Do you have any family members in our practice? ______________________________

______________________________ ______________
Patient/Guardian Signature *Date*

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