



PATIENT REGISTRATION

Patient Information:

First Name _____ Last Name _____ MI _____

Preferred Name _____ Sex _____ Age _____ Date of Birth _____

Marital Status _____ Social Security # _____

Drivers Lic. State and # _____ Home or Cell Phone _____ Work Phone _____

E-Mail Address _____

Home Address _____ City _____ ST _____ Zip _____

Employer's Name _____ Employer's Phone _____

Occupation _____ Employer's Address _____

Student status _____ School Name _____ Grade _____

Send Appointment reminders via: (circle one) Text Email Call

Please tell us where you heard about us (circle all that apply)

Friend or Relative _____ Ad in Mail Search Engine (google,etc)
Insurance company Our Website Ad in Phonebook (which one) _____

Other: _____

Person Responsible for Account

First Name _____ Last Name _____ MI _____

Relationship to patient _____ Date of Birth _____

Social Security # _____ Drivers Lic. State and # _____

Home or Cell Phone _____ Work Phone _____

E-mail Address _____

Employer's Name _____ Employer's Phone _____

Occupation _____ Employer's Address _____

Dental Insurance Information:

Primary Insurance Information

Insurance Holder's Name _____ Date of Birth _____

Relationship to patient _____ Employer _____

Member ID _____ Group # _____

Insurance Company Name _____ Insurance Company Phone _____

Insured's SSN _____ Insurance Company's Address _____

Secondary Insurance Information

Insurance Holder's Name _____ Date of Birth _____

Relationship to patient _____ Employer _____

Member ID _____ Group # _____

Insurance Company Name _____ Insurance Company Phone _____

Insured's SSN _____ Insurance Company's Address _____