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:_____

(Please turn over)

Person Responsible for Account if Different from Patient Information:

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_____