Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Date of Birth: _____ Social Security #: _____ Drivers License #: _____

Mailing Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____ Best Method of Contact: □ Phone □ E-Mail

Employment Status: □ Full Time □ Part Time □ Retired Employer: _____

Student Status: □ Full Time □ Part Time Name of School: _____

Responsible Party (If someone other than the patient, i.e.: Parent, Spouse):

First Name: _____ Middle Initial: _____ Last Name: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Date of Birth: _____ Social Security #: _____ Drivers License #: _____

Mailing Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____ Best Method of Contact: □ Phone □ E-Mail

Employment Status: □ Full Time □ Part Time □ Retired Employer: _____

□ Responsible Party is also Insurance Policy Holder Relationship to Patient: □ Spouse □ Parent □ Legal Guardian

Dental Insurance Information:

Subscribers Relationship to Patient: □ Spouse □ Parent □ Legal Guardian

First Name: _____Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____ Member ID #: _____

Mailing Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____ Best Method of Contact: □ Phone □ E-Mail

Employment Status: □ Full Time □ Part Time □ Retired Employer: _____

Insurance Company Name: _____ Provider Contact #: _____

Insurance Company Address: _____

_____ _____

Signature of patient, Guardian of patient or Parents Authorized Representative Date

_____ _____

Witness Date