Welcome

Patient Registration

Patient Last, First name ____ Birth Date __________________
Marital Status __________ Gender_____________

Address __________________________________ City, State, Zip ____

Home # ______________________ Work # __________________ext.______ Cell # ________________________________

SSN _________________________ Drive Lic. __________________________ Email _______________________________

Preference for confirmation of appointments (please circle): text / email / both

Emergency contact person ____________________ phone number __________________ Relationship ______________

Is patient responsible for paying bills? _____ Yes ___ No

Person responsible / Guarantor for paying bills

Last, First name ____ Birth Date_________________

Marital Status _____________ Gender ____________

Address ___________________________________ City, State, Zip ____

Home # ______________________ Work # ___________________ ext______ Cell # _____________________________

SSN _____________________________ Drive Lic. _____________________ Email ______________________________

Dental Insurance

Do you have **Primary** Dental ins.? ___Yes ___ No | Do you have **Secondary** ins.? ___Yes ___ No

Policyholder Last, First Name _____________________ | Policyholder Last, First Name ____________________________

Policyholder Address____________________________ | Policyholder Address ___________________________________

City, State, Zip __________________________________ | City, State, Zip ____

Birth Date _____________________________________ | Birth Date ____

Relationship to patient ___________________________ | Relationship to patient __________________________________

Employer Name _________________________________ | Employer Name _______________________________________

Insurance Name _________________________________ | Insurance Name _______________________________________

Insurance address________________________________ | Insurance address ____________________________________

Policyholder ID __________________________________ | Policyholder ID _______________________________________

Group # ________ Patient ID # ______________________ | Group # _________ Patient ID #__________________________

Ins. Phone # _____________________________________ | Ins. Phone # ____

Referred by or referral source: _____________________________________

Admin use: Date ___________________ Initials: _______________________