

### Patient Registration Form

Date: \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Male: \_\_\_\_\_

Address of patient: \_\_\_\_\_ Female: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_

Work Phone: \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Patient Employer: \_\_\_\_\_

Patient Employment Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Retired \_\_\_\_\_

Patient Student Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Name of College: \_\_\_\_\_

Patient is: Responsible party for account: Yes \_\_\_\_\_ No \_\_\_\_\_  
Policyholder for dental insurance: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of person responsible for bill: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Phone Numbers: \_\_\_\_\_

#### Primary Dental Insurance Information:

Name of Insured: \_\_\_\_\_ Patient's relationship to insured: \_\_\_\_\_

Insured SSN or ID numbers: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Group Number: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_