PATIENT REGISTRATION FORM

Patient Name: First_____**Last**_____
Date of Birth:_____ **Social Security#**_____
Marital Status: Single Married Divorced Widowed Male/ Female
Address of patient:_____
City:_____**State**:_____**Zip Code**:_____
Home Phone:_____**Work Phone**:_____**Cell Phone**:_____
E-Mail Address:_____**Would you like to receive E-Mail correspondences? Y N**
Patient Employer:_____
Patient Occupation:_____
Patient Employment Status: Full Time Part Time Retired
Patient Student Status: Full Time Part Time If College Student, Name of College:_____

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

Name of person responsible for bill:_____
Address: _____
City: _____**State**:_____**Zip Code**:_____
Home Phone: _____**Work Phone**:_____**Cell Phone**:_____
Date of Birth: _____**Social Security #**:_____
Name Of Employer: _____**Occupation:**_____
Employer's Address: _____

Emergency Contact:_____
Emergency Contact Number:_____

Primary Dental Insurance Information:
Name of Insured:_____**Patient's Relationship to Insured:**_____
Insured Soc. Sec. #_____**Insured Birth Date:**_____
Insured ID#_____**Group #**_____

Employer:_____	**Ins. Company:**_____
Address:_____	**Address**:_____
Address 2:_____	**Address 2:**_____
City,State,Zip:_____	**City,State,Zip:**_____

Secondary Dental Insurance:
Name of Insured:_____**Patient's Relationship to Insured:**_____
Insured Soc. Sec. or ID #(if different):_____**Insured Birth Date:**_____
Insured ID#_____**Group #**_____

Employer:_____	**Ins. Company:**_____
Address:_____	**Address**:_____
Address 2:_____	**Address 2:**_____
City,State,Zip:_____	**City,State,Zip:**_____

When was the last time you saw a dentist?_____
When was your last Cleaning and Exam?_____ **FMX**_____**Bitewing Xrays**_____
Who may we thank for referring you to our office?_____