Patient Registration

FORM DATE: ____/____/_____

Patient ID: _____ Chart ID: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ ____

First Name **Middle Initial** **Last Name**

Other Physician Name

Responsible Party (If someone other than patient)

Name

Patient Information

Street Address

City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____/____/_____ Social Security Number _____-_____-_____

E-mail Spouse Name

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: ____ Feet ____ Inches

Family Dentist

Medical Insurance Information

Primary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID No. Insured Birth Date ____/____/_____ Plan Name

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Secondary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Insurance Plan or Program Name

Insured Birth Date ____/____/_____ Sex: ☐ Male ☐ Female Insurance ID No.

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date: