PATIENT REGISTRATION FORM

Patient Information:

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

Nickname: _____ DOB: _____ Gender: M F

Address: _____

City: _____ State:_____ Zip code: _____

Social Security: _____/____ /_____ E-mail Address: _____

Main Phone Number: (____) _____ Cell Number: ____) _____

May we call you at work? Y N Work Number: (_____) _____

BEST WAY TO CONTACT YOU FOR BILLING: MAIL TEXT TO PAY LINK

Emergency Contact: _____Phone #:_____

Whom may we thank for referring you to our practice? _____

Responsible Party:

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Is this Person a Patient in our Office? Yes No

Address: _____

Birthdate: _____ Main Phone Number: (_____) _____

Dental Insurance Information:

Subscriber: _____ Relationship to Patient: _____

Subscriber Birthdate: _____ Subscriber SS#: _____ - _____ - _____

Subscriber Employer: _____ Work Phone Number: (_____) _____

Employer Address: _____

Insurance Carrier: _____ ID#: _____ Payor ID#: _____

Insurance Address: _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO **IF YES, COMPLETE THE FOLLOWING:**

Subscriber: _____ Relationship to Patient: _____

Subscriber Birthdate: _____ Subscriber SS#: _____ - _____ - _____

Subscriber Employer: _____ Work Phone Number: (_____) _____

Employer Address: _____

Insurance Carrier: _____ID#: _____ Payor ID#: _____

Insurance Address: _____