



PATIENT REGISTRATION

Welcome! Please complete the following confidential information.

1. Patient Information

SSN: _____ - _____ - _____

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

I prefer to be called _____

Birth Date: _____ Gender: Male _____ Female _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____

What is the best way for our office to contact you? _____

Who may we thank for referring you to our office or how did hear about us: _____

2. Dental Insurance

Primary Carrier

Secondary Carrier

Insurance Company: _____

Insurance Company: _____

Group Number: _____

Group Number: _____

Employer Name: _____

Employer Name: _____

Insured's Name: _____

Insured's Name: _____

Birth Date: _____ Relationship: _____

Birth Date: _____ Relationship: _____

Insured's ID Number: _____

Insured's ID Number: _____

Insured's SSN: _____

Insured's SSN: _____

3. Account Information

Person Financially Responsible for Account

4. Your Employment Information

Name: _____

Occupation: _____

Relationship: _____ SSN: _____

Employer: _____

Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Phone Number: _____

5. Additional Information Who would you like us to notify in case of an emergency?

Name: _____ Relationship: _____

Phone Number: _____

Send completed form to: frontdesk@pristineperioimplants.com