



## 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

Insurance Company: \_\_\_\_\_

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

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

Insured's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_

#### Secondary Carrier

Insurance Company: \_\_\_\_\_

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

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

Insured's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_

### 3. Account Information

#### Person Financially Responsible for Account

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

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

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

Phone Number: \_\_\_\_\_

### 4. Your Employment Information

Occupation: \_\_\_\_\_

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

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

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

Phone Number: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_