



REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: ____

Patient is: ☐ Policy Holder

☐ Responsible Party

Responsible Party

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

Address: _____ Address 2: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: ____ Cellular: _____

Birth Date: _____ Age: ____ Soc. Sec. _____ Driver License: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: ____ Cellular: _____

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

Birth Date: _____ Age: ____ Soc. Sec. _____ Driver License: _____

E-mail: _____ ☐ I would like to receive correspondences via email.

Referred by: _____ Previous Dentist: _____ Emergency Contact: _____ # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip Code: _____

City, State, Zip Code: _____

Rem. Benefits: _____

Rem. Deduct.: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip Code: _____

City, State, Zip Code: _____

Rem. Benefits: _____

Rem. Deduct.: _____

