PATIENT REGISTRATION

First Name:_____Last Name: _____Middle Initial: _____

Address: _____ City, State, Zip: _____

Birthdate: _____Sex: _____ Social Security Number: _____

Marital Status: _____ Email: _____

Home Phone Number: _____ Cell phone Number: _____

Emergency Contact: _____Phone Number: _____

Primary Care Physician and Phone Number: _____

Name of responsible party if patient is under the age of 18:_____

Do you have dental insurance? **Circle:** YES NO

Are you the policy holder on your insurance? **Circle:** YES NO

If no, name of the policy holder: _____Date of Birth: _____

Policy holder's Social Security number: _____Relation: _____

Name of insurance company: _____ID Number: _____

Address to send dental claims:

_____

_____

What employer is the insurance through (if any): _____

Group number on the card: _____Insurance Phone #: _____