PATIENT REGISTRATION

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

Preferred Name:_____ Patient is: □ **Responsible Party** □ **Policy Holder**

Patient Information:

Address:_____

City, State, Zip:_____

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

Sex: ○ Female ○ Male **Marital Status:** ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____/____/_____ Social Security #:_____-____-_____ Drivers Lic#:_____

E-mail:_____ □ **I would like to receive email correspondences**

Referred By:_____

Preferred Dentist:_____

Preferred Pharmacy:_____ Pharmacy Phone:_____

Primary Insurance Information:

Name of Insured:_____ **Relationship to Insured:** ○Self ○Spouse ○Child ○ Other

Member ID/Insured Social Security #:_____ Insured Birth date:_____

Insurance Company:_____ Employer:_____

Address:_____

City, State, Zip:_____

Insurance Phone:_____

Secondary Insurance Information:

Name of Insured:_____ **Relationship to Insured:** ○Self ○Spouse ○Child ○ Other

Member ID/Insured Social Security #:_____ Insured Birth date:_____

Insurance Company:_____ Employer:_____

Address:_____

City, State, Zip:_____

Insurance Phone:_____