

Patient Registration

Patient:

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

Mailing Address: _____ City _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Cell: _____

Date of Birth: _____ Soc Sec: _____ - _____ - _____

E-Mail Address: _____

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

Employment Status: Full Time Part Time Retired Referred By: _____

Student Status: Full Time Part Time N/A Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

➡ **We automatically send text messages to cellular numbers to confirm appointments. Please check ONLY if you DO NOT wish to have text messages sent to your cell phone: NO – I do not wish to be contacted by text messages.**

POLICY HOLDER FOR INSURANCE or Responsible Party: (If different from Patient)

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

Mailing Address: _____ City _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Cell: _____

Date of Birth: _____ Soc Sec: _____ - _____ - _____

Relationship to PT: _____ E-Mail: _____

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time N/A

➡ I do not have dental insurance and I am therefore prepared to pay in full for my appointment today

Dental Insurance Information: (please fill this section out as well as attach your card to the clipboard)

Insured is: PT Responsible Party Both Patient's relationship to insured: Child Spouse Other

Name of Insurance Company: _____

Member ID: _____ Group #: _____

Deductible: \$ _____ Employer: _____

Yearly Max: \$ _____ Employer Address: _____

City: _____ State: _____ Zip: _____