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: _____