

# PATIENT REGISTRATION

## PATIENT INFORMATION

Salutation: Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Miss \_\_\_\_\_ Dr. \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_  
Soc. Sec #: \_\_\_\_\_ Driver's License: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Soc. Sec #: \_\_\_\_\_ Driver's License: \_\_\_\_\_ E-mail: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Policy Holder's Soc. Sec. #: \_\_\_\_\_ Policy Holder's Birth Date: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Holder's ID Number: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Policy Holder's Soc. Sec. #: \_\_\_\_\_ Policy Holder's Birth Date: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Holder's ID Number: \_\_\_\_\_