



## PATIENT REGISTRATION

How did you hear about us? \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  Yes, send me Text Message alerts/reminders

Work Phone: \_\_\_\_\_

Gender:  Male  Female Marital Status:  Married  Single  Other: \_\_\_\_\_

E-mail Address: \_\_\_\_\_  Yes, send me alerts/reminders via E-mail

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information

No Dental Insurance

#### *Primary Insurance*

Insurance Company: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Member ID/SS#: \_\_\_\_\_ Group#: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other: \_\_\_\_\_

#### *Secondary Insurance*

Insurance Company: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Member ID/SS#: \_\_\_\_\_ Group#: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other: \_\_\_\_\_

### Responsible Party (If other than patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_