Patient Registration

First Name: ________________________ MI:___ Last Name:_____________________

Preferred Name: _______________________________ Date of Birth:______________

SSN:__________________ Gender: Male Female Responsible Party: Self Other

Contact Information

Address 1:

____

City: ______________________________________ State: _________ Zip Code:________

Phone Number: ___________________________ Home Work Mobile

Phone Number: ___________________________ Home Work Mobile

Do you want to receive text or emails reminding you of your appointments? Yes No

Email: ____

Preferences

Dentist:____Hygienist:__________

Pharmacy:____

Referral: _____________________________Referral Source:____________________

Insurance Info

Primary Insurance

Insurance company:______________________ Employer:______________________

Policy holder:______________________ Policy Holder DOB:____________________

Relationship to Policy Holder:____

Secondary Insurance

Insurance company:______________________ Employer:______________________

Policy holder:______________________ Policy Holder DOB:____________________

Relationship to Policy Holder:____