PATIENT REGISTRATION

DATE _____

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ Preferred Name _____

City, State, Zip _____ E-Mail _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Sex: ○ Male ○ Female

Responsible Party

First Name _____ Middle Initial _____ Last Name _____

Address _____ Sex: ○ Male ○ Female

City, State, Zip _____ E-Mail _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Spouses Name _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Primary Insurance Information

Name of Insured _____ Social Security# _____ Date of Birth _____

Patient relationship to insured: Self Spouse Child Other

Employer Name _____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____ **MEMBER ID#** _____

Secondary Insurance Information

Name of Insured _____ Social Security# _____ Date of Birth _____

Patient relationship to insured: Self Spouse Child Other

Employer Name _____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____ **MEMBER ID#** _____

Emergency Contact: **NOT LIVING IN SAME HOUSE**

Name _____

Phone # _____ Relationship to Patient _____

How did you choose Dental Professionals? _____

If by referral, who can we thank? _____