Patient Registration Form

Patient Information:

First Name: _____Middle Initial:_____ Last Name: _____

Preferred/Nickname: _____ DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work: _____

Occupation:_____ Employer:_____

Email address: _____

Referred By: _____

Emergency Contact:_____Phone #:_____

Whom may we thank for referring you to our office?_____

Responsible Party:

Name of person responsible for Account: _____ Relationship: _____

DOB: _____ Phone Number: _____ Existing Patient: YES / NO

Address: _____

City: _____, State: _____ Zip Code: _____

Dental Insurance Information:

Insurance Company: _____ Phone #: _____

Subscriber: _____ Subscriber DOB: _____ Relationship: Self / Spouse / Other

Subscriber Employer: _____ Subscriber ID: _____

Group Name: _____ Group Number: _____

Claims Mailing Address: _____

Payor ID: _____

Additional Dental Insurance Information: (if more than 2 insurance plans, provide information on the back of this form)

Insurance Company: _____ Phone #: _____

Subscriber: _____ Subscriber DOB: _____ Relationship: Self / Spouse / Other

Subscriber Employer: _____ Subscriber ID: _____

Group Name: _____ Group Number: _____

Claims Mailing Address: _____

Payor ID: _____