Patient Registration

First Name: ____ Last Name: ____Middle Initial: ________

Patient Is: Policy Holder
Responsible Party

Preferred Name: ____

Address: ____

City: ____ State: _____________________________ Zip Code: _______________________________

Home Phone: ______________________________ Cell Phone: _______________________________ Work Phone:__________________________

Sex : Male Female Marital Status: Married Single Divorced Separated Widowed

Birthdate: _______________________________ Soc. Sec.: _____________________________ Drivers Lic: __________________________________

Responsible Party Information (if someone other than the patient)

First Name: ____ Last Name: _______________________________________ Middle Initial: ________

Address: ____

City: ____ State: ________________________________ Zip Code: __________________________

Home Phone: _______________________________Cell Phone: _______________________________ Work Phone:___________________________

Sex : Male Female Marital Status: Married Single Divorced Separated ☐ Widowed

Birthdate: _______________________________ Soc. Sec.: _____________________________ Drivers Lic: __________________________________

Relationship to patient: ☐ Parent ☐ Spouse Child ☐ Other: ____

Dental Insurance Information

Policy Holder: ____Relationship to patient: Self Spouse Child Other

Policy Holder Soc. Security: ______________________________ Policy Holder's Birthdate: ____

Ins. Company: ____ Member ID: ____

Ins. Address: ____ Group ID: ____

City, State, Zip: ____ Ins. Phone Number: ____

Medical Insurance Information

Policy Holder: ____Relationship to patient: Self Spouse Child Other

Policy Holder Soc. Security: ______________________________ Policy Holder's Birthdate: ____

Ins. Company: ____ Member ID: ____

Ins. Address: ____ Group ID: ____

City, State, Zip: ____ Ins. Phone Number: ____