Patient Registration Form

Patient:

First Name MI Last Name

Preferred Name

Address City ST Zip

Date of Birth SS # □ M □ F Sex

Home # Work # Cell #

Email □ Yes □ No Text Message Reminders

Employer Phone #

Address City ST Zip

Insurance:

Primary Insurance Company ID #

Policy Holder Insured SS # Date of Birth

Primary Insurance Company ID #

Policy Holder Insured SS # Date of Birth

***Please provide the front desk with your insurance card.**

Emergency Contact:

Name Relationship Phone #

Responsible Party:

Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian □ Child □ Other

First Name MI Last Name

Address City ST Zip

Date of Birth SS #

How did you hear about our office? ***We offer Referral Rewards!!!***

□ Friend/Family □ Website □ Other

Previous Dentist Date of Last: Xrays Cleaning Treatment

Reason for Visit