PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:_____

Patient Information

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell Phone:_____

Date of Birth:_____ Social Sec #:_____ Drivers Lic #:_____

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

Email:_____ ☐ Confirm my appointments via text message

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Preferred Pharmacy:_____

Physician's Name:_____ Physician's #:_____

Emerg. Contact Name:_____ Emerg. Contact #:_____

Referred By:_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell Phone:_____

Date of Birth:_____ Social Sec #:_____ Drivers Lic #:_____

☐ Responsible Party is also a Policy Holder for PT ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Dental Insurance Information

Name of Policy Holder:_____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Social Secrity Number:_____ Insured Birth Date:_____

Dental Insurance ID Number:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

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

Secondary Dental Insurance Informaton

Name of Policy Holder:_____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Social Secrity Number:_____ Insured Birth Date:_____

Dental Insurance ID Number_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

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