Patient Registration

Patient Name: ___________________________________ **Social Sec#:** __________________________

Address: ____ **Email:** _______________________________

City, State & Zip: ____

Home Phone: ____________________________________ **Cell Phone:** __________________________

Sex: ☐ **M** ☐ **F** ☐ **Other:** __________________________ **DOB:** ________________________________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Child**

Patient employed by: ______________________________ **Occupation:** _________________________

Business Address: _________________________________ **Business Phone:** ______________________

Whom may we thank for referring you? ____

Emergency Contact: _______________________________ **Phone:** _______________________________

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Primary Insurance

Subscriber Name and DOB: ____

Subscriber Address: ____

Relationship to Patient: ____________________________ **Social Sec#**: ____________________________

Insurance Co Name / Address: ____

Subscriber ID #: ___________________________________ **Group #:** _______________________________

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Secondary Insurance

Subscriber Name and DOB: ____

Subscriber Address: ____

Relationship to Patient: ____________________________ **Social Sec#**: ____________________________

Insurance Co Name / Address: ____

Subscriber ID #: ___________________________________ **Group #:** _______________________________

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Dental History

Reason for Today's Visit: ____

Date of last dental visit: _____________________________ **Date of last X-Rays:** _______________________