



# 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:** \_\_\_\_\_  
Relationship: \_\_\_\_\_

## Primary Insurance

**Subscriber Name and DOB:** \_\_\_\_\_  
**Subscriber Address:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_ **Social Sec#:** \_\_\_\_\_  
**Insurance Co Name / Address:** \_\_\_\_\_  
**Subscriber ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

## Secondary Insurance

**Subscriber Name and DOB:** \_\_\_\_\_  
**Subscriber Address:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_ **Social Sec#:** \_\_\_\_\_  
**Insurance Co Name / Address:** \_\_\_\_\_  
**Subscriber ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

## Dental History

**Reason for Today's Visit:** \_\_\_\_\_  
**Date of last dental visit:** \_\_\_\_\_ **Date of last X-Rays:** \_\_\_\_\_