

Welcome

Patient Registration

PATIENT INFORMATION:

Name: _____ Birthdate: _____
Address: _____
Preferred method of contact (*circle all that apply*): **Home Phone** **Cell Phone/Text** **Email** **Work Phone**
Home #: _____ Work #: _____ Cell #: _____
Email: _____ Relationship to Account Holder(s): _____
Previous Dentist: _____ Who is responsible for this patient's bill: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

HOW DID YOU HEAR ABOUT US: _____

PRIMARY ACCOUNT HOLDER: (*person who holds insurance*)

Name: _____ Birthdate: _____
Home Address: _____
Preferred method of contact (*circle all that apply*): **Home Phone** **Cell Phone/Text** **Email** **Work Phone**
Home #: _____ Work #: _____ Cell #: _____
Email Address: _____ SSN: _____
Driver's License Number: _____ State: _____ Exp. Date: _____

EMPLOYER/PRIMARY INSURANCE INFORMATION:

Employer Name: _____ Phone: _____
Insurance Company: _____ Group #: _____
Insurance Address: _____ ID #: _____

SECONDARY ACCOUNT HOLDER:

Name: _____ Birthdate: _____
Home Address: _____
Preferred method of contact (*circle all that apply*): **Home Phone** **Cell Phone/Text** **Email** **Work Phone**
Home #: _____ Work #: _____ Cell #: _____
Email Address: _____ SSN: _____
Driver's License Number: _____ State: _____ Exp. Date: _____

EMPLOYER/PRIMARY INSURANCE INFORMATION:

Employer Name: _____ Phone: _____
Insurance Company: _____ Group #: _____
Insurance Address: _____ ID #: _____