# Welcome

## Patient Registration

**PATIENT INFORMATION:**

Name: _____ Birthdate: _____

Address: _____ City/State/Zip: _____

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: _____ City/State/Zip: _____

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: _____ City/State/Zip: _____

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 #: _____