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Patient Registration Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ ____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

How long have you been at this address? _____

Driver's License #: * _____

The following is for:* ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:* _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Number of years with this employer: _____

Dental Insurance Information

Name of Insured: _____* _____* ____
Last First MI

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insured Person's Date of Birth: * _____

Insured Person's ID #: * _____

Insured Person's Group #: * _____

Do you have Secondary Dental Insurance? If so, please complete the next section.

Name of Insured: _____* _____* ____
Last First MI

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insured Person's Date of Birth: _____

Insured Person's ID #: _____

Insured Person's Group #: _____

Please Provide us with your insurance card and a photo ID

I request and consent to treatment as necessary or desirable to the care of the patient first named above, including whatever medications, performance of operations and laboratory, x-ray, photographs, or other studies that may be used and/or forwarded by the attending doctor or his/her team or qualified designate including the referring or restorative doctor. I also certify that the above information is true and correct.

Signature _____ **Date** _____

Response Date: _____