Patient Registration Form

Date of Visit: _____/_____/_____ **PLEASE PRINT**

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: M / F
Mailing Address: _____
Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
Email Address: _____ Social Security Number: _____-_____-_____
Employer Name: _____ Employer Phone: (_____) _____-_____
Referring Dentist: _____ Primary Care Physician: _____
IS YOUR VISIT DUE TO A JOB RELATED OR AUTOMOBILE ACCIDENT? Y / N IF YES, PLEASE NOTIFY THE RECEPTIONIST

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____
Mailing Address: (if different from patient) _____
Home Phone: (____) _____-_____ Cell Phone: (_____) _____-_____

Insurance Information

Primary Insurance **Medical Policy [ ]** **Dental Policy [ ]**
Plan Name: _____ Policy Number: _____
Policy Holder: _____ Date of Birth: _____
Plan Address: _____ Social Security Number: _____-____-_____
Group Number: _____ Phone Number: (_____)_____-_____
Relationship to Patient: (please check) [ ] Self [ ] Spouse [ ] Parent [ ] Other _____

Secondary Insurance **Medical Policy [ ]** **Dental Policy [ ]**
Plan Name: _____ Policy Number: _____
Policy Holder: _____ Date of Birth: _____
Plan Address: _____ Social Security Number: _____-____-_____
Group Number: _____ Phone Number: (_____)_____-_____
Relationship to Patient: (please check) [ ] Self [ ] Spouse [ ] Parent [ ] Other_____

Tertiary Insurance **Medical Policy [ ]** **Dental Policy [ ]**
Plan Name: _____ Policy Number: _____
Policy Holder: _____ Date of Birth: _____
Plan Address: _____ Social Security Number: _____-____-_____
Group Number: _____ Phone Number: (_____)_____-_____
Relationship to Patient: (please check) [ ] Self [ ] Spouse [ ] Parent [ ] Other _____

Financially Responsible Party Information

Guarantor Name: _____ Date of Birth: _____/_____/_____
Relationship to Patient: (please check) [ ] Self [ ] Spouse [ ] Parent [ ] Other _____
Address: (if different from patient) _____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Guarantor Signature: _____

(I acknowledge that I am financially responsible for the payment whether or not covered by insurance)