



**REGISTRATION FORM**

**PATIENT INFORMATION**

Patient Is:	Policy Holder	Responsible Party (if someone other than the patient)					
First Name:		Last Name:		Middle Initial:		Preferred Name:	

Address:	Address 2:		Home Phone:	Work Phone:	Ext.:
City:	State:	Zip:	Cellular:	Pager:	

E-Mail:		I would like to receive correspondences via e-mail
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Birth Date:		Social Security #:		Driver License:				
Gender:	Male	Female	Marital Status:	Married	Single	Divorced	Separated	Widowed

**RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)**

First Name:		Last Name:		Middle Initial:		Preferred Name:	
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Address:	Address 2:		Home Phone:	Work Phone:	Ext.:
City:	State:	Zip:	Cellular:	Pager:	

Birth Date:		Social Security #:		Driver License:	
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**RESPONSIBLE PARTY IS ALSO**

Policy Holder for Patient	Primary Insurance Policy Holder	Secondary Insurance Policy Holder
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Employment Status:	Employer ID:		Emergency Contact:	
Full-Time	Medicaid ID:		Emergency Phone:	
Part-Time	Carrier ID:		Referred By:	
Retired	Preferred Pharmacy:		Previous Dentist:	
Student	Preferred Dentist/Hygienist:		Confirmation Status:	

**PRIMARY INSURANCE INFORMATION**

Name of Insured:					
Insured Social Security #:					
Insured Birth Date:					
Relationship to Insured:	Self	Spouse	Child	Other	
Employer:			Insurance Company:		
Address:	Address 2:		Address:	Address 2:	
City:	State:	Zip:	City:	State:	Zip:

**SECONDARY INSURANCE INFORMATION**

Name of Insured:					
Insured Social Security #:					
Insured Birth Date:					
Relationship to Insured:	Self	Spouse	Child	Other	
Employer:			Insurance Company:		
Address:	Address 2:		Address:	Address 2:	
City:	State:	Zip:	City:	State:	Zip: