Patient Registration

First Name | MI | Last Name

Address

City | State | Zip

Primary Phone | Secondary Phone

Driver's License # | Email

Birthdate | Social Security #

Emergency Contact / Relationship | Phone Number

Preferred Dentist | Preferred Hygienist

Preferred Pharmacy | Pharmacy Number

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Gender:

- ☐ Male
- ☐ Female
- ☐ Unspecified
- ☐ Other _____

Responsible Party (Same as Patient ☐ Yes or ☐ No)

First Name | MI | Last Name

Address

City | State | Zip

Primary Phone | Secondary Phone

Driver's License # | Email

Birthdate | Social Security #

Who can we thank for your visit with us today?

- ☐ Drive/Walk By
- ☐ Insurance Company
- ☐ Another Office _____
- ☐ Patient Referral _____
- ☐ Other _____
- ☐ Online Search
- ☐ Mailer
- ☐ Radio
- ☐ Staff

Primary insurance information

Policy Holder | Relationship to Patient

Insurance Company Name | Insurance Company Address

Insurance Company Phone | City, State, Zip

Employer Name | Employer Phone Number

Patient/Member ID | Group Number

Secondary insurance information

Policy Holder | Relationship to Patient

Insurance Company Name | Insurance Company Address

Insurance Company Phone | City, State, Zip

Employer Name | Employer Phone Number

Patient/Member ID | Group Number

Student Status: ☐ Full Time ☐ Part Time

Are there particular concerns you would like to discuss with the doctor?

- ☐ Toothache / Pain
- ☐ Removal of Wisdom Teeth
- ☐ Bridge / Partial / Denture
- ☐ Gum Bleeding / Pain
- ☐ Chipped or Cracked Tooth / Teeth
- ☐ Implants
- ☐ Other

Additional Information/Comments: