

# REGISTRATION FORM

Date \_\_\_\_\_

## PATIENT INFORMATION:

Name \_\_\_\_\_  
(first) (middle) (last)  
Address \_\_\_\_\_ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Sex – M / F Marital – Single/ Married /Divorced  
Full Time Student – Y / N Name of College \_\_\_\_\_  
Employer \_\_\_\_\_ / Position \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_

## SPOUSE INFORMATION:

Name \_\_\_\_\_  
(first) (middle) (last)  
Employer \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

## ACCOUNT INFORMATION:

Person Responsible for Account:

Name \_\_\_\_\_  
(first) (middle) (last)  
Address \_\_\_\_\_ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ / Position \_\_\_\_\_  
Address \_\_\_\_\_ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

## PRIMARY DENTAL INSURANCE:

Primary Dental Insurance Company \_\_\_\_\_ Ins. Phone # \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Employer \_\_\_\_\_  
Group # \_\_\_\_\_ Policy I.D. or SS # \_\_\_\_\_

Please list other family members covered by this insurance

Full name (s) \_\_\_\_\_

## SECONDARY DENTAL INSURANCE:

Insurance Company \_\_\_\_\_ Ins. Phone # \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Employer \_\_\_\_\_  
Group # \_\_\_\_\_ Policy I.D. or SS # \_\_\_\_\_

Please list other family members covered by this insurance

Full names (s) \_\_\_\_\_

Are you covered under medical assistance? \_\_\_\_\_

MA# \_\_\_\_\_ Birthdate \_\_\_\_\_

## ADDITIONAL INFORMATION:

Who may we thank for referring you to our office? \_\_\_\_\_

Is another member(s) of your family a patient at our office? \_\_\_\_\_

## IN CASE OF EMERGENCY:

Name of nearest relative (not living with you) \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_