PATIENT REGISTRATION

Patient Information

First Name: ______________________ Last Name: ______________________________ Middle Initial_____

Preferred First Name: _______________ Sex: ____Male ____Female

Address: __________________________________ City/State/Zip:_________________________________

Home Phone: _____________________ Cellular: ____________________ Work: ____________________

Birth Date: _______________ Age: ____ Soc. Sec. ______________________ Driver Lic. ______________

Email: ______________________________________ I would like to receive correspondence via email ________

Primary Dental Insurance Information

What is the Insurance Company you have dental coverage with? _______________________________________

Are you the Policyholder for your Dental Insurance? _____ Yes _____ No

Where are you employed? __________________________________

If you are **NOT** the Policyholder for your dental insurance please complete the information listed below:

First Name of Policyholder: ________________________ Last Name: ______________________________

Policyholder's Social Security # ________________________________ Birth Date: _____________________

Policyholder's Employer: ____

Secondary Dental Insurance Information

If you are the Policyholder of your Primary Insurance, do you have Secondary Dental Insurance through your Spouse?

If yes, what is the name of Insurance Company: ____

Spouse's First Name: ______________________ Spouse's Last Name: ___________________________

Spouse's Social Security # _________________________________ Birth Date:______________________

Spouse's Employer: ____