Patient Registration

Patient's Name ____

Date of Birth ____/____/____ Age____Sex: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

If a child, parent's name ____

Address ______________________________ Address 2 ______________________

City ______________________________ State __________ Zip ____________

Email ______________________________ Social Security No. ______-______-______

Current Employer ____

Present Position ______________________ How long held ______________________

Home Telephone ______________________ Work Phone ______________________

Cell Phone ______________________ Emergency Phone ______________________

Closest relative not living with you ______________________ Phone ______________

Referred By ____

Date of last Dental Exam ______________ Date of last Medical Exam ______________

Spouse Information

Name of Spouse ____

Spouse's Social Security No. _____-_____-_____ Spouse's Work Phone ______________

Employer ______________________ How long held ______________________

Primary Insurance Information

Name of Insured ______________________ Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insured Social Security _____-_____-_____ Insured Birth Date ______________________

ID # ______________________ Group # ______________ Employer ______________

Ins. Company ______________________ Ins. Phone Number ______________________

Ins. Address ______________ City ______________ State ________ Zip ____________

Secondary Insurance Information (If Applicable)

Name of Insured ______________________ Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insured Social Security _____-_____-_____ Insured Birth Date ______________________

ID # ______________________ Group # ______________ Employer ______________

Ins. Company ______________________ Ins. Phone Number ______________________

Ins. Address ______________ City ______________ State ________ Zip ____________

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