# REGISTRATION FORM

PATIENT'S NAME: Last_____ First_____ Middle Initial ___

Sex: M F (circle) Birthdate _____Age _____Marital Status_____

Parent or Guardian Name (if minor) _____ Today's Date _____

Reason for visit _____

Who May We Thank for Referring You to our Office? _____

## RESPONSIBLE PARTY INFORMATION

Name: Last_____ First_____ Middle Int _____

Address _____ City_____ State _____ Zip _____

Cell Phone # _____Home # _____ Work # _____

EMAIL _____ Social Security # _____

Birthdate _____ Relation to Patient _____ Employer _____

INSURANCE through employer? Y/N (circle)

## SPOUSE OF RESPONSIBLE PARTY

Name _____ Employer _____

Birthdate _____ Cell Phone # _____ Work # _____

EMAIL _____ Social Security # _____

INSURANCE through employer? Y/N (circle)

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

Name _____ Relationship to you _____

Cell Phone # _____ Home # _____

## DENTAL INSURANCE (PRIMARY CARRIER)

Employee Name _____ Insurance Co _____

Insurance Claim Address _____

Employer _____ Group or Plan # _____

Social Security # _____ Employee ID on card _____

## SECONDARY DENTAL INSURANCE

Employee Name _____ Insurance Co _____

Insurance Claim Address_____

Employer _____ Group or Plan # _____

Social Security # _____ Employee ID on card _____