PATIENT REGISTRATION

Patient Information

Name ______ Middle ______

Patient is: ☐ Policy holder ☐ Responsible party   Preferred Name ______

Address ______ Address 2 ______

City ______ State/Zip ______

Home Phone ______ Work Phone ______ Cellular ______

Sex: ☐ Male ☐ Female   Marital Status: ☐ Married ☐ Single ☐ Divorce ☐ Separated ☐ Widowed

Birth date ______ Age ______ Social Security ______ Drivers License ______

Email ______   ☐ I would like to receive correspondence via email ☐ Text message

Section 2

Pref. Dentist ______

Pref. Hygienist ______

Pref. Pharmacy ______

Pref. Pharmacy Location ______

Pref. Pharmacy Phone # ______

Section 3

Emergency contact ______

Emergency contact cell phone ______

Closest relative not living with you ______

Closest relative cell phone ______

Whom may we thank for referring you? ______

Responsible Party

Name ______ Middle ______

Address ______ Address 2 ______

City ______ State/Zip ______

Home Phone ______ Work Phone ______ Cellular ______

Birth date ______ Age ______ Social Security ______ Drivers License ______

Responsible Party Employer Name ______

Responsible Party Employer Address ______

City ______ State/Zip ______

Responsible Party Spouse's Name ______ Middle ______

Spouse's Social Security ______ Birth Date ______ Age ______

Spouse's Employer Name ______ Occupation ______

Spouse's Employer Address ______