Date

PATIENT REGISTRATION

Patient's Name ______________________ Birthdate ____________ Sex ☐ M ☐ F

Patient's Address ______________________ Phone ____________
Street City Zip

Patient's Employer ____________ Business Address ____________ Phone ____________

No. of Yrs. Employed _____ Soc. Sec. No. ____________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse ____________ No. of Dependents _______ Spouse's Soc. Sec. No. ____________

Spouse's Employer ____________ Whom May We Thank For Referring You ____________

Nearest Neighbor or Relative's Name, Address, and Phone No. ____________

Who Will Pay This Account? (Whose Name Will Appear on Billing Statement.)
☐ Self ☐ Spouse ☐ Parent or Guardian

If You Checked "Self" Please Skip Next Section and Continue with Insurance Section

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name ______________________ Birthdate ____________ Sex ☐ M ☐ F

Street Address (If Dif. Than Above) ______________________ Phone ____________
Street City State Zip

Responsible Party's Employer ____________ No. of Years Employed _____ Soc. Sec. No. ____________

Business Address ______________________ Phone ____________

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name ____________ Birthdate ____________ Soc. Sec. No. ____________

Subscriber's Employer ____________ Business Address ____________ Insurance Co. ____________

Group No. ____________ Deductible ☐ Yes ☐ No Max. Benefit ____________ Benefit Year ____________

Patients Relationship to Subscriber ☐Self ☐Spouse ☐Dependent

Have You Used Your Dental Insurance Previously? ☐Yes ☐No

Are You Covered Under More Than One Dental Plan? ☐ Yes ☐ No If Yes, Please Fill Out Next Section.

SECONDARY INSURANCE

Subscriber's Name ____________ Birthdate ____________ Soc. Sec. No. ____________

Insurance Co. ____________ Group No. ____________ Employer ____________ Relationship to Patient ____________

(Please Continue On Next Page)

FOR OFFICE USE ONLY

Primary Subscriber's Name ______________________ Family Member No. _______ Emp. No. _______

Secondary Subscriber's Name ______________________ Family Member No. _______ Emp. No. _______

Doctor ____________

Medical Message:
1 No Message 2 See Medical 3 Premedicate 4 See Medical and Premedicate 5 Allergies