Patient Registration

Please complete the following information. Any incorrect or information not provided could interrupt insurance payment and not allow us to best serve you.

First Name:_____Last Name:_____Date:_____

Address:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____ Cell:_____
E-mail:_____ Text to confirm: Y or N Circle one.
Birthdate:_____ Occupation:_____ SS#_____
Pharmacy Preference :_____ Phone:_____
Do you need to Pre-Medicate due to medical reasons for your dental visit?_____

Responsible Party (If someone other than patient if Insurance is involved)

First Name:_____ Last Name:_____

Address_____

City, State, Zip:_____

Home Phone:_____WorkPhone:_____ Cell:_____

Birthdate:_____ Soc. Sec._____

Primary Dental Insurance Information

Policy Holder Name: _____ Relationship to Patient:_____

Insured Soc. Sec:_____ Insured Birthday:_____

Employer:_____ Address:_____

Insurance Company:_____Address:_____

City, State, Zip_____ Group#:_____
Member ID #_____
Please have your insurance card with you we would like to make a copy to keep on file.
If you have Secondary Dental Insurance re-peat the Primary Insurance format below.