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Patient Registration

Today's Date:

Patient Information:		
Name:	Date of Birth: ○ Male ○ Female	
Address:	SS#:	
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
E-mail address:		Marital Status:
Would you like to receive correspondence via email? ○ Yes ○ No Email address:		○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Employer Information:	
Employer:	Employee ID:
Employer Address:	

Primary Dental Insurance Information:	Dental Insurance: ○ Yes ○ No
Name of Insured/ Policy Holder/ Responsible Party:	Date of Birth:
Name of Dental Insurance:	Phone:
Group Name:	Group Number:
Names of Patients covered under this policy:	

Secondary Dental Insurance Information:	Dental Insurance: ○ Yes ○ No
Name of Insured/ Policy Holder/ Responsible Party:	Date of Birth:
Name of Dental Insurance:	Phone:
Group Name:	Group Number:
Names of Patients covered under this policy:	

We will need a copy of your insurance card for our files. Thank You!

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and completed the above answers. I certify this information is current, true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Parent: *(if Minor)* _____ Date: _____