**Patient Registration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient is: | Policy Holder | Responsible Party | Preferred Name: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  | Middle Int: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | | Last Name: | |  | | | Middle Int: | |  |
| Address: |  | | Address 2: | |  | | | | | |
| City, State, Zip Code: | |  | | | | | Pager#: | |  | |
| Home Phone: |  | | Work Phone: | |  | | Cell Phone: | |  | |
| Birth Date: |  | | Soc Sec #: | |  | | Drivers Lic : | |  | |
| Responsible Party is also a Policy Holder for Patient | | | | Primary Insurance Policy Holder | | Secondary Insurance Policy Holder | | | | |

**Responsible Party**

**Patient Info**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | |  | | | | | | | | | Last Name: | | |  | | | | Pager #: |  |
| Zip Code: | |  | | |  | | | | | | | | | | | | |  | |
| Home Phone: | |  | | | | | Work Phone: | | |  | | | | | | Cell Phone: | |  | |
| Sex: | Male Female | | | Marital Status  Married  Single  Divorced  Separated  Widowed | | | | | | | | | | | | | | | |
| Birth Date: | |  | | | | Age | |  | Soc Sec | | |  | | | Drivers Lic # | |  | | |
| E-Mail Address: | | |  | | | | | | | | | | I would like to receive correspondences via e-mail | | | | | | |

|  |  |
| --- | --- |
| Do you have a fear of dentistry? |  |
| Are you interested in sedation? |  |
| Are you interested in Nitrous (laughing gas) |  |
|  |  |
|  |  |

**Employment Info**

|  |  |
| --- | --- |
| Employment Status: | Full time  Part time  Retired |
| Student Status: | Full time  Part time |
| Medicaid ID | |
| Employer ID | |
| Carrier Id | |

**Primary Insurance Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of insured: |  | Relationship to insured | | | | | Self  Spouse Child  Other | |
| Insured Soc. Sec: |  | Insured Date of Birth | | | | | |  |
| Employer: |  | Ins Company: | | |  | | | |
| Address: |  | Address: |  | | | | | |
| Address 2 |  | Address 2: | |  | | | | |
| City, State Zip |  | City, State, Zip | | | |  | | |
| Rem Benefits |  | Rem. Deduct: | | |  | | | |