Referred By: ____________ Date: __________

PATIENT REGISTRATION

First Name:__________________Last Name:___________________Middle Initial:___Pref. Name:_____________

Birthdate:___________SSN:_________________ Sex: Male_____ Female:

Address: ____City, St, Zip _________________________________

Home Phone:________________ Mobile Phone: ________________Email: _____________________________

Employer:_____________________________________ Phone:_______________ Occupation: ______________

Student? F/T P/T Name of School: ____

Marital Status: Married: _______Single: _______Divorced: _______Separated: _______Widowed: _______

Spouse:_______________________________ SSN:____________________ Occupation:__________________

Employer:_____________________________ Phone: ___________________

Emergency Contact Person:________________________________ Relationship: _________________________

Address:____ Phone: ____________________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:___________________________________ Relationship: _____________________

Residence Address:____ C/S/Z: __________________________

Phone #:______________________ SSN: ____________________________

***phone number needs to be the mobile number of the insured.**

_______ (Please initial). I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

Employer: ____ # of Years Employed:____________

Employer's Address:____ C/S/Z:____________________________

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name: _________________________SSN/ID:___________________Insured Birth Date: ____________

Patient's Relationship to Insured: Self:__________ Spouse:_________Child: ________ Other: ___________

Insurance Company:___________________________________Phone #:_______________________

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name: _________________________SSN/ID:___________________Insured Birth Date: ____________

Patient's Relationship to Insured: Self:__________ Spouse:_________Child: ________Other: ___________

Insurance Company:___________________________________Phone #: _____________________

(Rev. 4/05)