Patient Registration

First Name: ______________________ **MI:** ___ **Last Name:** ______________________

Preferred Name: ______________________ **Date of Birth:** ____________ **Gender:** ☐ Male ☐ Female

Responsible Party: ☐ Self ☐ Other ____

Contact Information

Patient Address: ☐ Own ☐ Other ____

Address 1: ____

Address 2: ____

City: ______________________ **State:** ______ **Zip Code:** ______________

Phone Number: ____________________ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** ________________

Phone Number: ____________________ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** ________________

Phone Number: ____________________ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** ________________

Phone Number: ____________________ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** ________________

Email: ____________________________________

Email: ____________________________________

Preferences

Dentist: __________________________ **Hygienist:** __________________________

Pharmacy: ____

Patient Registration

Previous Dentist: ____

Address 1: ____

Address 2: ____

City: ______________________ State: ________ Zip Code: ______________

Notes:

Referral: ______________________ Referral Source: ______________________

Patient Insurance

Primary Insurance Information

Carrier Name: ______________________ **Effective Date:** ______________

Address 1: ____

Address 2: ____

City: ______________________ **State:** ______ **Zip Code:** ______________

Plan Name: ______________________ **Policy Holder ID:** ______________

Policy Holder: ☐ Self ☐ Other______________ **Policy Holder Date of Birth:** ______________

Relationship to Policy Holder: ______________________ ☐ Dependent Child Coverage Only

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Plan #2 Insurance Information

Carrier Name: ______________________ **Effective Date:** ______________

Address 1: ____

Address 2: ____

City: ______________________ **State:** ______ **Zip Code:** ______________

Plan Name: ______________________ **Policy Holder ID:** ______________

Policy Holder: ☐ Self ☐ Other______________ **Policy Holder Date of Birth:** ______________

Relationship to Policy Holder: ______________________ ☐ Dependent Child Coverage Only

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Plan #3 Insurance Information

Carrier Name: ______________________ **Effective Date:** ______________

Address 1: ____

Address 2: ____

City: ______________________ **State:** ______ **Zip Code:** ______________

Plan Name: ______________________ **Policy Holder ID:** ______________

Policy Holder: ☐ Self ☐ Other______________ **Policy Holder Date of Birth:** ______________

Relationship to Policy Holder: ______________________ ☐ Dependent Child Coverage Only

Patient Insurance

Plan #4 Insurance Information

Carrier Name: ______________________ **Effective Date:** ______________

Address 1: ______________________________

Address 2: ______________________________

City: ____________________ State: ______ Zip Code: ______________

Plan Name: ____________________ Policy Holder ID: ______________

Policy Holder: ☐ Self ☐ Other ______________ Policy Holder Date of Birth: ______________

Relationship to Policy Holder: ______________ ☐ Dependent Child Coverage Only

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Plan #5 Insurance Information

Carrier Name: ____________________ Effective Date: ______________

Address 1: ______________________________

Address 2: ______________________________

City: ____________________ State: ______ Zip Code: ______________

Plan Name: ____________________ Policy Holder ID: ______________

Policy Holder: ☐ Self ☐ Other ______________ Policy Holder Date of Birth: ______________

Relationship to Policy Holder: ______________ ☐ Dependent Child Coverage Only

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Plan #6 Insurance Information

Carrier Name: ____________________ Effective Date: ______________

Address 1: ______________________________

Address 2: ______________________________

City: ____________________ State: ______ Zip Code: ______________

Plan Name: ____________________ Policy Holder ID: ______________

Policy Holder: ☐ Self ☐ Other ______________ Policy Holder Date of Birth: ______________

Relationship to Policy Holder: ______________ ☐ Dependent Child Coverage Only