

# Patient Registration Form

**Patient Information** - Please PRINT clearly.

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Single  Married  Divorced  Widowed

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

E-mail \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employed by \_\_\_\_\_

Employer's Address \_\_\_\_\_

## **Emergency Information**

Who should we contact in the event of an emergency? \_\_\_\_\_

Relationship \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

Family Physician Name /Phone # \_\_\_\_\_

## **Person Financially Responsible for this Account:**

Responsible Party's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Street Address \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who can we thank for referring you to our practice? \_\_\_\_\_

Are you a college student? FT PT School \_\_\_\_\_ Location \_\_\_\_\_

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## **Dental Insurance Information (please provide insurance card)**

### **Primary Carrier:**

Name of Policy Holder \_\_\_\_\_

Policy Holder's ID # \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

### **Secondary Carrier:**

Name of Policy Holder \_\_\_\_\_

Policy Holder's ID # \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled.

Signature of Patient /Responsible Party \_\_\_\_\_ Date \_\_\_\_\_