

Patient Registration

Patient Information:

First name: _____	Last name: _____	Middle Initial: _____
Address: _____		
City, State, Zip: _____		
Home phone: (____) _____ - _____	Work phone: (____) _____ - _____	Cell: (____) _____ - _____
Email Address: _____		
Birth date: _____ Social Security #: _____		
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____		
Pronouns: <input type="checkbox"/> He/His <input type="checkbox"/> She/Hers <input type="checkbox"/> They/Them		
Do you use a pre-medication prior to dental treatment? _____		
Emergency contact: _____ (____) _____ - _____		

Responsible Party:

: Same as above

First name: _____	Last name: _____	Middle Initial: _____
Address: _____		
City, State, Zip: _____		
Home phone: (____) _____ - _____	Work phone: (____) _____ - _____	Cell: (____) _____ - _____
Birth date: _____ Social Security #: _____		
<input type="checkbox"/> Responsible Party is also the Policy Holder for Patient		
<input type="checkbox"/> Primary Insurance Holder		
<input type="checkbox"/> Secondary Insurance Holder		

Insurance Information (please provide insurance card)

Name of Insured: _____	
Relationship to patient:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Insured SSN: _____	Insured Date of Birth: _____
Employer: _____	Insurance Company: _____
Insurance phone number: _____	Group number: _____
Subscriber ID #: _____	

Secondary Insurance Information

Name of Insured: _____	
Relationship to patient:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Insured SSN: _____	Insured Date of Birth: _____
Employer: _____	Insurance Company: _____
Insurance phone number: _____	Group number: _____
Subscriber ID #: _____	

Patient or Guardian Signature: _____