PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial_____

Preferred First Name: _____ Sex: ____Male ____Female

Address: _____ City/State/Zip:_____

Home Phone: _____ Cellular: _____ Work: _____

Birth Date: _____ Age: ____ Soc. Sec. _____ Driver Lic. _____

Email: _____ I would like to receive correspondence via email _____

Please provide your Pharmacy information.

Pharmacy: _____ Location/Address: _____

Pharmacy Phone Number: _____

"Primary" Dental Insurance Information

What is the Insurance Company you have dental coverage with? _____

Are you the Policyholder for your Dental Insurance? _____ Yes _____ No

If you are the Policyholder, where are you employed? _____

If you are **NOT the Policyholder** for your dental insurance, **please complete the information listed below:**

First Name of Policyholder: _____ Last Name: _____

Policyholder's Social Security # _____ Birth Date: _____

Policyholder's Employer: _____

"Secondary" Dental Insurance Information

Do you have **Secondary** Dental Insurance through your Spouse?

If yes, what is the name of Insurance Company: _____

Spouse's First Name: _____ Spouse's Last Name: _____

Spouse's Social Security # _____ Birth Date:_____

Spouse's Employer: _____
