PATIENT REGISTRATION

Patient Information   Please PRINT clearly. Thank you.

First name: ____________________ Last name: ____________________ Middle Initial: ________

Address: ____ Apt. Number :____________

City:______________________________ State:____________ Zip: ________________

Home phone :(______) _______-____________ Cell: (______) _______-__________ Text Messaging: □ Opt In □ Opt Out (See Below**)

Email address:____ Email: □ Opt In □ Opt Out (See Below**)

Birth Date: ____________________ Age: _______ Social Security #: ____________________

Sex: □ Male □ Female Marital Status: □ Married □Single □ Divorced □ Separated □ Widowed

Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer:____________________ City, State: ____________________ Work phone: (_____) _____-________

Student Status: □ Full Time □ Part Time Name of School____________________ City, State: ____________________

Preferred Pharmacy:____

Physicians Name:____ Phone:____________________

Main Dental concern:____

Do you use a pre-medication prior to dental treatment (Anti-biotic)? ____________________

How did you find our office? (Referral Source)____

EMERGENCY CONTACT ____ Phone:(______) _______-__________

**We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messaging rates apply.

Responsible Party (if someone other than patient)

First name: ____________________ Last name: ____________________ Middle Initial: ________

Address: ____ Apt. Number :____________

City:______________________________ State:____________ Zip: ________________

Home phone :(______) _______-____________ Work phone: (______) _______-__________ Cell: (______) _______-___________

Birth Date:____________________ Soc. Sec: ____________________ Relationship to Patient:____________________

□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Policy Holder:____ **Policy Holder Birth Date**:____________________

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder SSN-or-**ID #**:____________________

Address (if different than patient's):____

City:______________________________ State:____________ Zip: ________________

Name of Policy Holder's Employer:____ City, State:____________________

Name of Insurance Company:______________________________ Address:______________________________

City:______________________________ State:____________ Zip: ________________