DENTAL HEALTH CLINIC PATIENT REGISTRATION

Patient Information:

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____

Street and mailing address: _____ City: _____

State, Zip: _____ Employer: _____

Phone: Home/Cell_____ Work Phone: _____

May we contact you by text? ○ Yes ○ No

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Birth Date: _____

SS#: _____

Email: _____ May we contact you by email? ○ Yes ○ No

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

CONTACT PHONE: _____

How did you hear about our office? Online/Phone Book/Referral/Previous Patient

Spouse Information: ○ Not Applicable, skip to next section

Spouse First Name: _____ MI_____ Last Name: _____

Spouse Phone Number_____ Spouse Date of Birth: _____

Spouse SS#_____

Spouse Employer_____ Spouse's work #_____

Is the Patient the Responsible Party? ○ YES, skip to next section ○ NO, PLEASE FILL OUT

First Name: _____ MI: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home/Cell Phone: _____ Relationship to Patient: ○Self ○Spouse ○Child ○Other

Birth Date: _____ SS#: _____

Employer_____ Work Phone: _____

Dental Insurance Policy Holder Information: Dental Insurance? ○ YES, please fill out ○ NO, skip this section

○ Policy Holder is Responsible party, skip this section.

Policy Holder First Name: _____ MI: _____Last: _____

Employer (if policy is a group policy): _____Work Phone: _____

Address: _____ City, State, Zip: _____

Phone Number: _____Patient's relationship to Insured: ○Self ○Spouse ○Child ○Other

Birth Date: _____ SS#: _____ ID#:_____

To File any insurance, we need the physical card presented due to the many different policies and claim addresses. Please provide the physical front & back of your dental insurance card

Thank you for taking the time to fill this out in its entirety!