

**PATIENT REGISTRATION**

PLEASE PRINT DATE: \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME # \_\_\_\_\_ BS# \_\_\_\_\_ CELL # \_\_\_\_\_

IF PATIENT IS A MINOR, WHO IS LEGALLY RESPONSIBLE?

\_\_\_\_\_

WHO TO CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_

PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

PRIMARY INSURANCE CO: \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

SS# \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_ POLICY/GROUP # \_\_\_\_\_

SECONDARY INSUR. INFO. \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SS # \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ POLICY/GROUP # \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PHONE # \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

IF PRESENTLY UNDER PHYSICIAN CARE – LIST REASON:

\_\_\_\_\_