Patient Registration Information

Please fill out all available information on this page and bring it to your appointment or send it to us in advance. Without complete information we are unable to process insurance claims.

Patient Information

Last Name	First Name	Middle Name
Prefers to be called:		
Street Address		
City	State	Zip
Home Phone	Work Phone	Mobile Phone
e-mail address		
Sex	Marital Status	SS Number
Birthday		

Account Information

Same as Patient Info?

Last Name	First Name	Middle Name
Street Address		
City	State	Zip
Home Phone	Work Phone	Mobile Phone
e-mail address		
Sex	SS Number	Birthday
Relationship to the patient:		

Getting to know you

Is a member of your family or a relative a patient at our office?

Name	Relationship
Who referred you to our office?	
In an emergency, who should we call?	

Relationship	Home Phone	Work Phone

Insurance Information

Primary Dental Insurance

Note: This is your own plan if you are insured through your work, or your spouse or oldest parent if you don't have insurance on your own.

Name of the Insured Party	Relationship to Patient
Insured's Employer	
Insured's Birthday	Insured's SSN
Insurance Plan Name	Group Number
Insurance Company Name	
Insurance company mailing address name	
Insurance company Street or P.O. Box	

City	State	Zip
Insurance Company Phone Number		

Secondary Dental Insurance

Note: This will be your spouse's plan if you are covered on each other's plan, or your youngest parent if you are covered on both parents' plans.

Name of the Insured Party	Relationship to Patient
Insured's Employer	
Insured's Birthday	Insured's SSN
Insurance Plan Name	Group Number
Insurance Company Name	
Insurance company mailing address	
Insurance company mailing address name	
Insurance company Street or P.O. Box	

City	State	Zip
Insurance Company Phone Number		