

**PATIENT REGISTRATION AND INFORMATION FORM**

Today's Date \_\_\_\_\_ Have you been seen in our office before? \_\_\_\_\_ When? \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ Social Security# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ Sep \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_ Address \_\_\_\_\_  
Emergency Phone & Contact \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Referred By \_\_\_\_\_ Dentist's Name \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
What is the reason for your visit? \_\_\_\_\_ College (if student) \_\_\_\_\_

**BILLING INFORMATION**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Policy Holder's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Policy Holder's Soc Security # \_\_\_\_\_ Birth Date \_\_\_\_\_  
Policy Holder's Certificate or ID# \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (if applicable)**

Policy Holder's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder's Soc Security # \_\_\_\_\_ Birth Date \_\_\_\_\_  
Policy Holder's Certificate # or ID \_\_\_\_\_ Group # \_\_\_\_\_