Patient Registration

PATIENT NAME (Last, First, Middle Initial)		DATE OF BIRTH
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS ☐Single ☐Married
HOME PHONE	CELL PHONE	SEX ☐Male ☐Female
DO YOU PREFER: ☐Morning Appointments ☐Afternoon Appointments		RELATIONSHIP TO INSURED ☐Self ☐Spouse ☐Child
EMPLOYER		WORK PHONE
OCCUPATION		E-MAIL ADDRESS

Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Referred to this office by:

NAME	PHONE

Insurance Information

Primary Coverage	Secondary Coverage
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION
SIGNATURE	DATE

Benefits (For Office Use Only)

Calendar Year _____ Yearly Plan Maximum $_____ Deductible $ _____ Class 1_____% Class 2 _____% Class 3_____% Coverage for: FMX _____Prophy_____ Sealants_____ BW _____ Fluoride _____ MTC:	Calendar Year _____ Yearly Plan Maximum $_____ Deductible $ _____ Class 1_____% Class 2 _____% Class 3_____% Coverage for: FMX _____Prophy_____ Sealants_____ BW _____ Fluoride _____ MTC:

Electronic Payor ?_____ Payor ID: _____ Mail Claims to: _____