**Patient Registration**

**Patient Information:**

Date of Birth: _____ SSN: _____

First Name: _____ Last Name: _____Middle Initial: _____

Preferred Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email address: _____

Would you like to receive correspondence via e-mail? YES NO

Would you like to receive text message reminders? YES NO

Patient Employed by: _____

Spouse Name: _____ Spouse Employed by:_____

**Responsible Party Information:**

Date of Birth: _____ SSN: _____

First Name: _____ Last Name: _____Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Email address: _____

**Dental Insurance information:**

**Primary Insurance Information:**

Name of Insured: _____

Insured date of birth: _____

Employer: _____

Name of Insurance Co: _____

Policy or ID number: _____

Group number: _____

Address: _____

_____

Telephone: _____

**Dental**

**Secondary Insurance Information:**

Name of Insured: _____

Insured date of birth: _____

Employer: _____

Name of Insurance Co: _____

Policy or ID number: _____

Group number: _____

Address: _____

_____

Telephone: _____

Current Primary Care Physician: _____

Preferred Pharmacy: _____

Who should we notify in case of emergency: _____

Phone number: _____

Other family members in this practice: _____

Who may we thank for this referral: _____

Patient or Guardians Signature: _____Date:_____