Today's date: _____/_____/_____

CONFIDENTIAL PATIENT REGISTRATION FORM
PLEASE PRINT NEATLY in black or blue pen and PLEASE COMPLETE ENTIRE FORM

First name: _____ Last name: _____ Middle initial: _____

SSN: _____ Date of birth: _____/_____/_____ Gender: _____

Marital status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed

Home Address: _____ City:_____

State:_____ Zip:_____ Email: _____

Home Phone: _____ Cell Phone: _____

May we contact you by (check all that apply): ☐ cell ☐ text ☐ home phone ☐ email

Emergency Contact Person:_____ Relationship:_____

Emergency Contact Home Phone: _____ Cell phone: _____

If patient is a minor:

Legal guardian's full name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Guardian's SSN: _____

Dental Insurance: Primary ☐ **I do not have dental insurance**

Policy Holder Name: _____ Employer Name:_____

Insurance Co. Name: _____ Ins co state: ____ Ins co phone:_____

Policy Holder SS#: _____ Member ID#_____

Policy Holder birthdate: _____/_____/_____ Grp# _____

Dental Insurance: Secondary (parents' plan, if under age 26; spouse; retiree dental plan, etc.)

Policy Holder Name: _____ Employer Name:_____

Insurance Co. Name: _____ Ins Co state: ____ Ins Co Phone:_____

Policy Holder SS#: _____ Member ID#_____

Policy Holder birthdate: _____/_____/_____ Grp# _____

Preferred Pharmacy: _____ Street name: _____

Pharmacy phone #: _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____