Welcome! Thank you in advance for filling out this Patient Registration Form.

We value your privacy and information. We ask for social security and drivers license numbers only because your dental insurance company requests this information when checking your eligibility for benefits.

Patient Information

Full Name: ____
Last *First* *M.I.*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Birthday: ________________ **Gender:** M / F

Home Phone: ____________________________ ___ Social Security Number: ____________________________

Mobile Phone:
and carrier ____________________________ ___ Drivers License Number: ____________________________

(We ask for your phone carrier so that our computer system can properly send you text messages)

Would you be interested in having communications send to you via email address or text message**?**
For example: appointment reminders**?** **Y / N**
If Yes, please provide email: ____

Person or Parent responsible for bill (Complete only if different from patient)

Guarantor Name: ______________________ SS# Number : ____________________ Birthday: ___________________

Relationship to Patient: ☐ Spouse ☐ Parent **Gender:** M / F

Address: ____ Phone: _____________________________

Employer Name: ____ Employer Phone: _____________________________

Employer Address: ____

***Who do we call in an emergency? Name:** __________________________ **Phone #:** _________________________

PLEASE PROVIDE INFORMATION BELOW ON YOUR INSURANCE THAT YOU WOULD LIKE US TO WORK WITH ON YOUR BEHALF FOR SERVICE FEES

First Insurance Information:
Plan Name: _______________________________________ I.D. Number: ________________________________
Address: ____ Group Number: ______________________________
Policy Holder Name:_______________________________ Effective Date: ______________________________
Policy Holder's SS#: _______________________________
Policy Holder's Birthday: ____________________________ **Gender:** M / F

Second Insurance Information:
Plan Name: _______________________________________ I.D. Number: ________________________________
Address: ____ Group Number: ______________________________
Policy Holder Name:_______________________________ Effective Date: ______________________________
Policy Holder's SS#: _______________________________
Policy Holder's Birthday: ____________________________ **Gender:** M / F