Patient Registration Form

Patient Name (Last): ______________________ (First) ___________________ MI: ______
DOB _____/_____/_____ SS# ______-_____-_____ Gender: M/ F
Address: ____
City: ____________________ State: ___________ Zip: ___________
Home Phone: _________________ Cell Phone: _______________ Work Phone: _____________
Email Address: ____
Pt. Allergies: ____
Emergency Contact Name: ______________________________ Relationship to patient: ___________
Emergency Contact Number: ____
Ethnicity of Patient: ______________________ Race of Patient: ___________________

Responsible Party Information
Responsible Party Name (Last) ________________________ (First) ____________________ MI: ___
Also Known As Name (Last) _______________________ (First) ____________________ MI: ____
SS# _____-_____-_____ Gender: M / F DOB: _____/_____/_____
Email address: ____
Home Phone: ____________________ Cell Phone: _________________ Work Phone: ___________
Address: ____
City: __________________________ State: ___________ Zip: ___________
Patient Relationship to Responsible Party: _____________________________________

Medical Insurance Information Provide your insurance card to the front desk at check-in
Primary Insurance:
Name of Insured: ______________________________ Patient Relationship to Insured: _______________
Insured Employer Name: ____
Insurance Company/Phone Number: ________________________________ (_____) ______________
Subscriber ID (Policy Number): ______________________________ Group ID: _______________
Effective Date: __________________________ Termination Date: ________________________
Insured DOB _____/_____/_____ Insured SS# _____-_____-_____

Secondary Insurance:
Name of Insured: ______________________________ Patient Relationship to Insured: _______________
Insured Employer Name: ____
Insurance Company/Phone Number: ________________________________ (_____) ______________
Subscriber ID (Policy Number): ______________________________ Group ID: _______________
Effective Date: __________________________ Termination Date: ________________________
Insured DOB _____/_____/_____ Insured SS# _____-_____-_____

Dental Insurance Information Provide your insurance card to the front desk at check-in
Primary Insurance:
Name of Insured: ______________________________ Patient Relationship to Insured: _______________
Insured Employer Name: ____
Insurance Company/Phone Number: ________________________________ (_____) ______________
Subscriber ID (Policy Number): ______________________________ Group ID: _______________
Effective Date: __________________________ Termination Date: ________________________
Insured DOB _____/_____/_____ Insured SS# _____-_____-_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____________________________ Date _________________