



## PATIENT REGISTRATION FORM

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  M  F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Parent and/or Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ (ext.): \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver Licenses Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Or if student  Part Time  Full Time Name of School: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_ Pharmacy Number \_\_\_\_\_

Are you a veteran/active duty/member of reserves or national guard?  YES  NO

### Primary Insurance Information

Policy Holder \_\_\_\_\_ Relation to Policy Holder  Self  Spouse  Child  Other

Policy Holder SSN # \_\_\_\_\_ Policy Holder Birthday \_\_\_\_\_

Employer \_\_\_\_\_ Employers Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Member ID \_\_\_\_\_ Group # \_\_\_\_\_

### Secondary Insurance Information

Policy Holder \_\_\_\_\_ Relation to Policy Holder  Self  Spouse  Child  Other

Policy Holder SSN # \_\_\_\_\_ Policy Holder Birthday \_\_\_\_\_

Employer \_\_\_\_\_ Employers Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Member ID \_\_\_\_\_ Group # \_\_\_\_\_

How did you hear about our office:

- Referred by Patient. Who? \_\_\_\_\_  Internet Search  Dental Insurance Carrier  
 Referred by one of our employees. Who? \_\_\_\_\_  Social Media  Other Source? \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_