

PATIENT REGISTRATION FORM

- (1) DATE: _____
- (2) TYPE OF INSURANCE: PPO, HMO/DMO, UNION, DISCOUNT PLANS, CASH
- (3) NAME OF INSURANCE COMPANY: _____
- (4) INSURANCE PLAN CODE: _____

POLICY HOLDER'S INFORMATION

- (5) LAST NAME: _____ FIRST NAME: _____ M.I. _____
- (6) GROUP NUMBER: _____ (7) MEMBER ID: _____ (8) SS#: _____
- (9) MEMBER DATE OF BIRTH: _____ (10) INSURANCE EFFECTIVE DATE: _____
- (11) EMPLOYER NAME: _____
- (12) EMPLOYER ADDRESS: _____
- (13) EMPLOYER PHONE #: _____
- (14) SEX: MALE FEMALE
- (15) IF PATIENT IS SAME AS POLICY HOLDER, CHECK HERE AND GO TO (21), OTHERWISE CONTINUE

- (16) PATIENT LAST NAME: _____ FIRST NAME: _____ M.I.: _____
- (17) RELATIONSHIP WITH PRIMARY MEMBER: SPOUSE CHILD
- (18) SEX: MALE FEMALE (19) PATIENT DATE OF BIRTH: _____
- (20) PATIENT SS#: _____ (21) E-MAIL: _____
- (22) ADDRESS: (STREET/APT): _____
CITY: _____ STATE: _____ ZIP: _____
- (23) MARITAL STATUS: SINGLE, MARRIED, WIDOWED, SEPARATED, DIVORCED
- (24) SPOUSE OR PARENT'S NAME: _____
- (25) WHOM MAY WE THANK FOR REFERRING YOU: _____
- (26) IF THE PATIENT IS A MINOR, NAME OF PARENT / GUARDIAN: _____
- (27) RELATIONSHIP WITH MINOR: _____
- (28) PURPOSE OF VISIT: EMERGENCY REGULAR OTHER _____
- (29) HOME PH#: _____ (30) WORK PH#: _____
- (31) CELL #: _____ (32) EMERGENCY PH#: _____
- (33) PREVIOUS DENTIST NAME: _____ PHONE #: _____
- (34) IF STUDENT: FULLTIME PART TIME SCHOOL NAME: _____