

# REGISTRATION FORM

## SECTION 1 PATIENT INFORMATION

LAST NAME			FIRST	M.I.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER				DATE	
ADDRESS		APT #	CITY	STATE	ZIP	BIRTHDATE					
PLACE OF EMPLOYMENT (OR SCHOOL)				GRADE	HOME PHONE	OFFICE PHONE	HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO				

## SECTION 2 DENTAL INSURANCE COVERAGE(S)

INSURANCE COMPANY						POLICY NUMBER		EFFECTIVE DATE	
EMPLOYER						GROUP NUMBER			
LAST NAME		FIRST	M.I.	RELATIONSHIP TO PATIENT SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/>					
BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER		HOME PHONE		OFFICE PHONE			

### SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY						POLICY NUMBER		EFFECTIVE DATE	
EMPLOYER						GROUP NUMBER			
SUBSCRIBER LAST NAME		FIRST	M.I.	RELATIONSHIP TO PATIENT SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/>					
BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER		HOME PHONE		OFFICE PHONE			

## SECTION 3 ACCOUNT RESPONSIBLE PARTY

LAST NAME			FIRST	M.I.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER				
ADDRESS		APT #	CITY	STATE	ZIP	BIRTHDATE				
RELATIONSHIP TO PATIENT SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER <input type="checkbox"/> (EXPLAIN)		PLACE OF EMPLOYMENT (OR SCHOOL)			HOME PHONE	OFFICE PHONE				
PERSON TO CONTACT IN CASE OF EMERGENCY				HOME PHONE	OFFICE PHONE					

## AUTHORIZATION

**I ACCEPT THE FINANCIAL RESPONSIBILITY OF THIS ACCOUNT. THE INFORMATION ON THIS PAGE IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
ACCOUNT RESPONSIBLE PARTY

\_\_\_\_\_  
DATE