101ST ADULT DENTISTRY
Patient Registration

Patient Information

First Name ________________________ M.I. _________ Last Name_______________________ Nickname________________________

Sex ☐ Male ☐ Female Birthdate ______________________ Age _____________ SSN ___________________________________

Street ___________________________________ City ___________________________ State ______________ ZIP______________

Home Tel (_______)_________________________ Cell (_________)____________________ Email _______________________________

Employer _________________________________ Bus Tel (_________) __________________________

Employed ☐ Full Time ☐ Part time ☐ Retired ☐ Not Employed

Medical Doctor ______________________________ Emergency Contact Name _____________________ Tel (_______)______________

How did you hear about us? ____

Student ☐ Yes ☐ No Full Time ☐ Part time ☐ School Name____

Marital Status ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐Single

If patient is minor, who is legal guardian? ☐ Father ☐ Mother ☐ Other____________,

Name_______________________________ Tel (_____) ___________________________

Spouse, Guarantor, or Responsible Party Information-**Information must be completed if patient is a minor**

Name ____ SSN ___________________________ Birthdate ___________________

Street ____ City _________________________ State _________ ZIP ________________

Home Tel (________)_______________________ Other Contact Tel (_________) ________________________

Employer, if employed ___________________________________ Bus Tel (________) _____________________________

Insurance Information

Primary Insurance

Subscriber ____ Relationship ___________________ Sex ☐ Male ☐ Female

Birthdate of Subscriber (person who carries insurance)_______________ SSN ____

Employer____ Employer Tel (________) __________________________________

Insurance Company Name__________________________________ Policy # _____________________________ Group# ________________

Secondary Insurance

Subscriber ____ Relationship ___________________ Sex ☐ Male ☐ Female

Birthdate of Subscriber (person who carries insurance)_______________ SSN ____

Employer____ Employer Tel (________) __________________________________

Insurance Company Name__________________________________ Policy # _____________________________ Group# ________________