The Dental Group Patient Registration Form

PATIENT INFORMATION

First Name: _____________________Middle I:__ Last Name: __________________________ Preferred Name: _____________

Address: ____
(Street) *(City)* *(State)* *(Zip)*

Phones: _(____)___________________ _(____)___________________ _(____)___________________
(Home) *(Work)* *(Cell)*

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _________________ Soc. Sec. No.: _____-______-_____ Driver's Lic. No: ________________________________
(Mo/Date/Yr) *(Include state if other than New York)*

Email Address: _______________________________________ Referred by: ____

Emergency Contact: ____ ___________________________
(Name) *(Phone)*

RESPONSIBLE PARTY (*if other than patient*)

First Name: ________________________________Middle I:____ Last Name: ____

Address: ____
(Street) (City) (State) (Zip)

Relationship to patient: ☐ Parent ☐ Guardian ☐ Other (*please indicate*): _________________________________

INSURANCE INFORMATION

Policy Holder Name (*if other than patient*) ____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: (*please indicate*): ___________________________

Policy Holder Birth Date: _____-______-________ Policy Holder Soc. Sec. No.: _______-______-_______
(Mo/Date/Yr)

Policy Holder Employer Name: ____

Address: ____
(Street) *(City)* *(State)* *(Zip)*

Insurance Company Name: ____

Address: ____
(Street) *(City)* *(State)* *(Zip)*

Member ID #: _____________________________ Group #: ____________________

EMPLOYMENT STATUS : ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

STUDENT STATUS (*if applicable*): ☐ Full-Time ☐ Part-Time

PATIENT PREFERRED PHARMACY: ____
(Name) *(Location)* *(Phone No.)*

Signature of Patient or
Responsible Party: ____ Date: ________________