PATIENT REGISTRATION-ADULT

FIRST NAME: _____ LAST NAME: _____ Preferred Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Mobile: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Social Security # _____

Email: _____ Driver's License # _____

Sex: ____ Male ___ Female Marital Status ____ Single ___Married ___ Other

Emergency Contact Name: _____ Relationship to Patient _____

Emergency Phone Number: _____

Referring Dentist Name: _____ City _____

Physician's Name & Number _____

Preferred Pharmacy: _____ City _____

Pharmacy Phone: _____

*** After 1/1/2023 all prescriptions must be electronically submitted. We will not be allowed to to call in prescriptions or give written prescriptions to patients.**

Responsible Party: (if different than patient information)

Relationship to Patient: ___ Spouse ___ Parent ____ Other

First Name: _____ Last Name _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Mobile _____ Work _____

Dental Insurance Primary Carrier

Insurance Company: _____ Employer _____

Date of Birth _____ Group # _____ Subscriber ID# _____

Dental Insurance Secondary Carrier

Insurance Company: _____ Employer _____

Date of Birth _____ Group # _____ Subscriber ID# _____