PATIENT REGISTRATION (MINOR/INSURED DEPENDANT)

Patient Name: ____

Address: __________________________________ P.O. Box__________

City: ____________________________State:________Zip:___________

Sex : M / F Age:_________ Nickname:______________________

Home phone:_________________ Cell:___________________ E-mail___________

Birth date:________________ School attending_______________________

Living with: Both natural parents____Natural mother____Natural father____
Other____________

Father's Name:____

Address:____P.O. Box__________

City:_______________________ State:_______ Zip:_________ DOB_________

Home phone:______________ Cell:________________ Ok to leave message? Y N **E-mail_______________**

Employer:__________________________ Employer phone#_________________

Mother's Name:____

Address:____P.O. Box____________

City:_______________________ State:________ Zip:________ DOB___________

Home phone:______________ Cell:________________ Ok to leave message? Y N **E-mail_______________**

Employer:____________________________Employer phone#__________________

In case of emergency, notify my nearest relative/acquaintance not living with me

Name:___________________________________Relationship:_________________

Phone:____________________________ Cell:________________________________

Name of my Dentist____
I was referred by ____

Please complete other side

Primary Dental Insurance

Name of Subscriber_____________________ DOB__________________

Policyholder SS#/ID#______________________ Group#____________

Insurance Company_________________________ Phone________________

Insurance Address____________________________

City_____________ State________ Zip_______________

Secondary Dental Insurance

Name of Subscriber_____________________ DOB__________________

Policyholder SS#/ID#______________________ Group#____________

Insurance Company_________________________ Phone________________

Insurance Address____________________________

City_____________ State________ Zip_______________

Primary Medical Insurance

Name of Subscriber_____________________ DOB__________________

Policyholder SS#/ID#______________________ Group#____________

Insurance Company_________________________ Phone________________

Insurance Address____________________________

City_____________ State________ Zip_______________

Secondary Medical Insurance

Name of Subscriber_____________________ DOB__________________

Policyholder SS#/ID#______________________ Group#____________

Insurance Company_________________________ Phone________________

Insurance Address____________________________
City_____________ State________ Zip_______________