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"Your Smile is Our Passion"

## **PATIENT REGISTRATION**

| First name:                             |                  | Last Name:             |                         |              | Middle Initial: |           |  |
|---|------------------|------------------------|-------------------------|--------------|-----------------|-----------|--|
| Preferred name:                         |                  |                        |                         |              |                 |           |  |
|   |                  |                        |                         |              |                 |           |  |
| Patient Information:                    | Addross 2:       |                        |                         |              |                 |           |  |
| Address: State: State:                  | ZIP: Birth       | Date:                  | -                       |              |                 |           |  |
| Home Phone:                             | E                | mployment Status: (    |                         | DPart-Time ( | ORetired        |           |  |
| Cell Phone:                             | S                | tudent Status:         | O <sub>Full</sub> -Time | OPart-Time   | e               |           |  |
| Work Phone:                             |                  |                        |                         |              |                 |           |  |
| Email:                                  | O <sub>l w</sub> | ould like to receive e | email correspo          | ndences via  | email           |           |  |
| Social Security #:                      | Drivers I        | License #:             |                         |              |                 |           |  |
| Sex: OMale OFemale                      |                  | Pat                    | ient is: $O_P$          | olicy Holder |                 | ble Party |  |
|   |                  |                        |                         |              |                 |           |  |
| Responsible Party (If someone other the | in the patient): |                        |                         |              |                 |           |  |
| First name: Last No                     | ame:             | Middle Initia          | l:                      |              |                 |           |  |
|   |                  |                        |                         |              |                 |           |  |
| Address:                                | Address 2:       |                        |                         |              |                 |           |  |
| City: State:                            | ZIP: Birth       | Date:                  | -                       |              |                 |           |  |
|   |                  | -                      |                         | -            |                 |           |  |
| Home Phone:                             |                  | nt Status: OFull-Tin   | $\sim$                  |              | k               |           |  |
| Cell Phone:<br>Work Phone:              | Student Sto      | atus: OFull-T          | ime OPart-T             | ime          |                 |           |  |
|   |                  |                        |                         |              |                 |           |  |
|   |                  | $\sum C$               |                         |              |                 |           |  |
| Primary Insurance Information:          |                  | <u>Sec</u>             | ondary Insura           | nce Informat | tion:           |           |  |
| Name of Insured:                        |                  | Na                     | me of Insured:          |              |                 |           |  |
| Insured Birth Date:                     |                  | Insu                   | ired Birth Date         | :            |                 |           |  |
| Relationship to Insured:                |                  | Rel                    | ationship to In         | sured:       |                 |           |  |
| Self Spouse Child                       | Other            |                        | Self                    | Spouse       | Child           | Other     |  |
| Employer:                               | State, Zip       | Em                     | oloyer:                 |              | State           | e, Zip    |  |
| Employer Address:                       |                  | Em                     | oloyer Addres           | s:           |                 |           |  |
| Insurance Company:                      |                  | Insu                   | rance Compo             | any:         |                 |           |  |
| Manalaar ID .                           |                  |                        | mber ID:                |              |                 |           |  |
| Insurance Company Address:              |                  |                        | •                       |              | :               |           |  |
| State, Zip                              |                  | Sta                    | te, Zip                 |              |                 |           |  |