

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____ Age: _____ Birth Date: _____ Male Female

Patient First Name MI Last Name Name you go by

Address _____ City _____ State _____ Zip _____

Home Phone: () _____ If Minor, Parent's Name: _____

Cell Phone: () _____ Beeper () _____

Driver's License No. _____ Social Sec. Number: _____

Spouse's Name: _____ Email Address: _____

EMPLOYMENT

Patient Employer _____ Occupation: _____

Employer Address _____ Work Phone: () _____

Spouse's Employer _____ Occupation: _____

Employer Address _____ Work Phone: () _____

EMERGENCY INFORMATION

If an emergency, Notify: _____

Relation: _____ Phone: () _____ Work: () _____

Address: _____

Closest Relative not living with you: _____

Address: _____ Phone: () _____ Work: () _____

INSURANCE INFORMATION

Primary Carrier

Secondary Carrier

Insurance Company: _____

Insurance Company: _____

Employee: _____

Employee: _____

Employer: _____

Employer: _____

Group Number: _____

Group Number: _____

Emp. Soc Sec No. _____

Employee Soc Sec No. _____

Employee Birthdate _____

Employee Birthdate: _____

REFERRAL INFORMATION

Referred by: _____

I am legally responsible for payment of my bills made by my dependents or myself for dental care rendered by Dr. Kent Herndon or Dr. Darren Crosbie.

Signature _____ Date: _____