PREMIER DENTAL
Family & Cosmetic Dentistry

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Patient is: ____ Policy Holder Preferred Name: _____
____ Responsible Party

Patient Information:

Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Date of Birth: _____ Age: _____ SSN#: _____
Sex: _ Male _ Female **Marital Status:** __ Married __ Single __ Divorced __ Widowed
Employment Status: ___ Full Time ___ Part Time ____ Retired
Student Status: ____ Full Time ___ Part Time
Referred By: _____
Emergency Contact: _____ Emergency Contact #: _____

Confirmation Calls are done via email and text messaging. Please provide the email address and cell phone number you would like them sent to:

Email: _____ Cell: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Date of Birth: _____ Age: _____ SSN#: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse _ Dependent
Insured SSN#: _____ Insured DOB: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information if applicable

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse _ Dependent
Insured SSN#: _____ Insured DOB: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____