Patient Registration

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext _____

Cell Phone: _____ I would like text message reminders: ☐ Yes ☐ No

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Employer Name: _____

Birth Date: _____ Soc. Security: _____ Drivers Lic: _____

E-mail: _____ I would like to receive e-mail correspondence ☐ Yes ☐ No

Emergency Contact: _____ Emergency Phone #: _____

Pref. Pharmacy: _____ How did you hear about our office? _____

Patient Is: ☐ Insurance Policy Holder ☐ Responsible Party

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Best contact number: _____ Birth Date: _____ Soc. Sec: _____

Dental Insurance Information:

Subscriber Name: _____ Subscribers birth date: _____

Employer: _____ Insurance Company: _____

Group #:_____ Member ID #: _____

I agree that the above information is accurate and complete. I will notify Dentistry on Vine immediately with any changes with my contact or insurance information.

Signature**:** _____ Date: _____