Beavers
FAMILY DENTISTRY

PATIENT REGISTRATION

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

Patient is: ⬭ Policy Holder ⬭ Responsible Party Preferred Name:_____

RESPONSIBLE PARTY (if someone other than patient)

First Name: _____ Last Name: _____Middle Initial: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Birth Date: _____ Social Security: _____

PATIENT INFORMATION

Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Birth Date: _____ Social Security: _____

Sex: ⬭ Male ⬭ Female Marital Status: ⬭ Married ⬭ Single ⬭ Divorced ⬭ Widowed

Email: _____ ⬭ I would like to receive correspondence via email.

Employment Status: ⬭ Full Time ⬭ Part Time ⬭ Retired

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ⬭ Self ⬭ Spouse ⬭ Child ⬭ Other

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ⬭ Self ⬭ Spouse ⬭ Child ⬭ Other

Insured Social Security: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____