TRUE DENTAL SPECIALTIES

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***How did you hear about our office?_____

PATIENT REGISTRATION

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

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

Responsible Party (if someone other than the patient)

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

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ EXT:_____ Cell Phone:_____

Birth Date: _____ Soc Sec#: _____ Driver's Lic:_____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone:_____ EXT:_____ Cell Phone:_____

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

Birth Date: _____ Soc Sec#:_____ Driver's Lic:_____

Email: _____ ◯ I would like to receive correspondences via email

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Primary Insurance Information

Name of Insured: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date: _____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip:_____

Rem Benefits:_____ Rem. Deduct:_____

Seconday Insurance Information

Name of Insured: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date:_____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip:_____

Rem Benefits:_____ Rem. Deduct:_____