Patient Registration 2

Patient Registration

First Name

_____

MI

_____

Last Name

_____

Preferred Name

_____

Date of Birth

_____

SSN

_____

Gender

☐ Male

☐ Female

☐ Other

Marital Status

☐ Single

☐ Married

☐ Widowed

☐ Divorced

☐ Separated

Address

_____

City

_____

State

_____

Zip Code

_____

Email

_____

Cell Phone

_____

Home Phone

_____

Work Phone

_____

Contact Preference

☐ Cell Phone

☐ Home Phone

☐ Work Phone

☐ Email

☐ Text

How did you hear about our office?

_____

Preferred Pharmacy: Location and Phone Number

_____

Thank You for choosing Virdi Dental. We appreciate the opportunity to take care of you. We look forward to providing you with high quality dental care.

Emergency Contact: Name, Phone Number and Relationship

_____

Information for Repsonsible Party if it is NOT the above patient:

First Name:

_____

Last Name:

_____

Address:

_____

City:

_____

State:

_____

Phone Number:

_____

Primary Dental Insurance Information

Primary Insurance

☐ None ☐ New ☐ Existing

Patient Relationship to Subscriber

☐ Self

☐ Spouse

☐ Child

☐ Dependent

Subscriber

_____

Subscriber ID Number

_____

Subscriber Employer

_____

Insurance Company Name

_____

Subscriber Date of Birth:

_____

Subscriber SSN

_____

* We cannot bill your dental insurance without your social security number

Secondary Insurance

☐ None ☐ New ☐ Existing

Secondary Dental Insurance Information

Patient Relationship to Subscriber:

☐ Self

☐ Spouse

☐ Child

☐ Dependent

Subscriber

_____

Subscriber ID Number

_____

Subscriber Employer

_____

Insurance Company Name

_____

Subscriber DOB

_____

Subscriber SSN:

_____