PATIENT REGISTRATION

Patient Information

Last Name: ______________________________ First Name: __________________ Middle Initial: ____

Address: ____ Address2: _________________________

City: ______________________ FL: _______________ Zipcode: _______________

Home Phone: ____________________ Work Phone: __________________ Cellular: __________________

Sex: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ______________ Age: __ Soc. Sec: __________ Drivers Lic: ____________________________

Email: _________________________________ ◯ I would like to receive correspondences via e-mail

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

With whom are you employed? (if applicable) ____

Does your employment cause you stress? Explain ____

Rank your stress level on a scale of 1 to 10 (1=least, 10=most) _____________

Pre. Dentist: __________________

Pref. Pharmacy: _______________

Primary Insurance Information

Name of Policy Holder: _________________________________ Policy Holder Birth Date: _______________

Relationship to Policy Holder: ◯ Self ◯ Spouse ◯ Child ◯ Other

Policy Holder Soc. Sec: ______________________ Group #: ______________________________________

Employer: __________________________________

Address: ___________________________________

Address2: __________________________________

City: _______________________ State: ________

Zipcode: ________________

Ins. Company: _______________________________

Address: ____________________________________

Address2: ___________________________________

City: ________________________ State: ________

Zipcode: ________________