Riversbend DENTAL

PATIENT REGISTRATION

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

Preferred Name: _____

Patient Is: ☐ Policy Holder

☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

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

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondances via email.

Employment Status: ◉ Full Time ◯ Part Time ◯ Retired

Student Status: ◉ Full Time ◯ Part Time

Emergency Contact Person: _____ Phone: _____

Other Family Members Seen By Us: _____

Whom May We Thank For Referring You: _____

Additional Comments:

Primary Insurance Information

Name Of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____

Secondary Insurance Information

Name Of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____