MIDWEST DENTAL
SPECIALISTS

# Patient Registration

## Patient Information

Date: _____

Name*: _____
Last* First* MI (Preferred)

Birthdate*: _____ Gender*: ☐ M ☐ F ☐ Unknown Social Security Number: _____

### Patient Contact Information

Home Phone: _____ Work Phone: _____ Cellular Phone*: _____

Email: _____

Preferred Contact Method*: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Select one of the following statuses*: ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Widowed

Who were you referred from? _____

Have we ever treated a family member in our office? _____

### Address

Address*: _____

Address 2: _____

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

### Emergency Contact Information

Full Name*: _____ Phone Number (Daytime)*: _____

### Responsible Party Information

Is the patient the Responsible Party? ☐ Y ☐ N

**If the responsible party is someone other than the patient, please fill out fields below.**

Name: _____
Last First MI (Preferred)

Birthdate: _____ Gender: ☐ M ☐ F ☐ Unknown

### Dental Insurance Policy

Please present insurance card to administrative personnel at time of appointment.

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

If you and/or the Responsible Party are not the Subscriber, please fill out Subcriber's information below.

Subscriber Name: _____ Subscriber's Birthdate: _____

Subscriber ID #: _____ Social Security Number: _____

**If you have Secondary Dental Insurance, please inform staff at time of your appointment.**