Prestonbrook
Dental

PATIENT REGISTRATION

ID:______________________________ Chart ID:____

First Name:________________________ Last Name:________________________ Middle Initial:__

Preferred Name: ____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: ________________________ Last Name: ________________________ Middle Initial:__

Address: ___________________________ Address 2: _______________________________________

City, State, Zip: ____

Home Phone:____________________ Work Phone: __________________ Cell Phone: ______________

Birth date: __________________ Social Security #: ________________ Drivers Lic#: ______________

Email: _____________________________________ □ I would like to receive email correspondences

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _________________________ Address 2: ____

City, State, Zip: ____

Home Phone: __________________ Work Phone: ____________________ Cell Phone: ________________

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

Birth date: ___________________ Social Security #: _______________ Drivers Lic#: _______________

E-mail:_____________________________________ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist: ______________________ Preferred Hygienist: ______________________

Preferred Pharmacy: ______________________ Ph#: ______________________

Referred By: ______________________

Medicaid ID: ______________________

Primary Insurance Information:

Name of Insured: ______________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ______________________ Carrier ID: ______________________

Insured Social Security #: ______________________ Insured Birth date: ______________________

Employer: ______________________ Insurance Company: ______________________

Address: ______________________ Address: ______________________

Address 2: ______________________ Address 2: ______________________

City, State, Zip: ______________________ City, State, Zip: ______________________

Secondary Insurance Information:

Name of Insured: ______________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ______________________ Carrier ID: ______________________

Insured Social Security #: ______________________ Insured Birth date: ______________________

Employer: ______________________ Insurance Company: ______________________

Address: ______________________ Address: ______________________

Address 2: ______________________ Address 2: ______________________

City, State, Zip: ______________________ City, State, Zip: ______________________

Thank You!