# Patient Registration Form

***Patient Information***

Legal Name: _____ Preferred Name: _____

Preferred Pro-noun: _____

Address: _____

City, State, ZIP Code: _____

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

E-Mail Address: _____

Birth Date: _____ Social Security #: _____

Sex at birth:
☐ Male ☐ Female

Identified Gender:
☐ Male ☐ Female ☐ Non-Binary

Marital Status: ☐ Single ☐ Married/ Domestic Partnership ☐ Divorced ☐ Widowed

Referred to us by: ☐ another patient _____ ☐ Insurance ☐ Other_____

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***Insurance Information*** ☐ No Insurance

Insured: ☐ Self ☐ Spouse/ Partner ☐ Parent

Gender associated with dental insurance:
☐ Male ☐ Female

Name of Insured: _____

Birth Date: _____ Social Security #: _____

Employer: _____ Insurance Carrier: _____

Group #: _____ Carrier ID #: _____

**Emergency Contact Name**: _____
Last First

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

***I have received a copy of the notice of privacy practice as required by the Health Insurance Portability and Accountability Act of 1996 ( HIPAA). To the best of my knowledge, the questions on this form and the medical history have been accurately answered.***

**Patient Signature:_____ Date:_____**