Patient Registration

Patient is: Policy Holder ☐ Responsible Party ☐ Preferred Name: ____________________

Responsible Party (if someone other than the patient)

First Name: ____________________ Last Name: ____________________ M.I.: _____

Address 1: ____________________ Address 2: ____________________

City: ____________________ State: _______ Zip: __________ Pager: __________

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

Birth Date: __________ Social Security: __________ Driver's License: __________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Holder

☐ Secondary Insurance Policy Holder

Patient Information **Patient Name:** ____________________

Address 1: ____________________ Address 2: ____________________

City: ____________________ State: _______ Zip: __________ Pager: __________

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

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

Birth Date: __________ Age: _____ Social Security: __________ Driver's License: __________

Email: ____________________ ☐ I would like correspondences via email

Emerg. Contact: ____________________ Relationship to Patient: __________

Emergency #: ____________________

Mother's Name: ____________________ Father's Name: ____________________

Primary Insurance Information

Name of Insured: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: ____________________ Insured Birth Date: ____________________

Employer: ____________________

Address: ____________________

Address2: ____________________

City, State, Zip: ____________________

Rem. Benefit: __________ Rem Deduct: __________

Ins. Company: ____________________

Address: ____________________

Address 2: ____________________

City, State, Zip: ____________________

If you have secondary insurance, please notify our office upon your arrival.

MILLS PARK DENTAL, P.A.