

**ORTHODONTIC DEPARTMENT**  
**PATIENT REGISTRATION**

Account # \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**I. PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_ M \_\_\_ F  
Last First Initial month / date / year

Address \_\_\_\_\_  
Street Apt. # City Zip

Phone (\_\_\_\_\_-) \_\_\_\_\_ Phone (\_\_\_\_\_-) \_\_\_\_\_  
Home Work

Employer's name \_\_\_\_\_ Address \_\_\_\_\_

Patient's General Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ Marital Status \_\_\_\_\_

**II. BILLING INFORMATION (If different from above)**

Responsible Party: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_  
Street Apt. # City Zip

Phone (\_\_\_\_\_-) \_\_\_\_\_ (\_\_\_\_\_-) \_\_\_\_\_ May we contact you at Work? \_\_\_ Yes \_\_\_ No  
Home Work

Birth date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
month / date / year

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_

**III. INSURANCE INFORMATION -Do You Have ORTHODONTIC insurance? \_\_\_ Yes \_\_\_ No**

Do you have two insurance carriers? Yes \_\_\_ No \_\_\_

**PRIMARY COVERAGE:**

Employee Name \_\_\_\_\_  
Last First Initial

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
month / date / year

Name of Ins. Co. \_\_\_\_\_

Union Local \_\_\_\_\_ Group \_\_\_\_\_

**SECONDARY COVERAGE:**

Employee Name \_\_\_\_\_  
Last First Initial

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
month / date / year

Name of Ins. Co. \_\_\_\_\_

Union Local \_\_\_\_\_ Group \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO DENTIST** - I hereby authorize payment of the Group Insurance Benefits otherwise payable to me directly to the dentist.

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date