Southside Dental Clinic
PATIENT REGISTRATION

Patient Information

First Name: ______________ _________Last Name: __________________________ Middle Initial: ____

Preferred Name: _________________ Whom may we thank for referring you?____________________

Address: ____

City: _________________________________State: ______ Zip: ______________

Home Phone: _______________Cell Phone: ____________________Work Phone: __________________

Sex: □ Male □ Female Soc. Sec:_____________________________________

Martial Status: □ Married □ Single □ Minor □ Divorced □ Separated □ Widowed

Birthdate: ______________ Age: ________Email: ____

Emergency Contact: ______________________________ Phone: ______________________________

Responsible Party (if someone other than patient)

First Name:________________________Last Name: __________________________Middle Initial:_____

Relationship to Patient: ______________ Address: ____

City: _______________________________________State________Zip Code: ______________

Birth Date: _____________________Social Security #: ______________________________

Home Phone: ________________Work Phone: ________________ Cell Phone: ___________________

Primary Insurance

Name of Insured:_______________________________________Insured Birthdate:_________________

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other ____________

Insured Soc. Sec. / Member Id: ____

Employer: _______________________________Ins. Company: ________________________________

Secondary Insurance

Name of Insured: ___________________________________ Insured Birthdate: ____________________

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other _____________________

Insured Soc. Sec. / Member Id: ______________________________