Bismarck FAMILY DENTAL PC

PATIENT REGISTRATION

RESPONSIBLE PARTY INFORMATION (if someone other than the patient):

Full Name: _____

Address: _____

City/State/Zip Code: _____

Home phone: _____

Cell phone: _____

☐ I would like to receive correspondences via text.

Email: _____

☐ I would like to receive correspondences via email.

Birthdate: _____

SSN: _____

Driver's License Number: _____

Employer: _____

Work phone: _____

PATIENT INFORMATION:

Full Name: _____

Address: _____

City/State/Zip Code: _____

Home phone: _____

Cell phone: _____

☐ I would like to receive correspondences via text.

Email: _____

☐ I would like to receive correspondences via email.

Birthdate: _____

Sex (circle one): Male Female

SSN: _____

Driver's License Number: _____

Marital Status (circle one): Married Single

Emergency Contact: _____

Emergency Contact Phone: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____

Insured SSN: _____

Insured Birthdate: _____

Employer: _____

Employer's Address: _____

City, State, Zip Code: _____

Relationship to the Insured (circle one):
Self Spouse Child Other

Insurance Company: _____

Address: _____

City, State, Zip: _____

Policy Primary Member ID: _____

Plan Number ID: _____

Secondary Insurance? Be sure to let us know!