



**Dr. David Hubbell - Patient Registration – Revised October 26, 2010**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

**Responsible Party** (if someone other than the patient)

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

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

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hygienist: \_\_\_\_\_

**Section 3**

Referred By: \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_  
 Emergency Name & #: \_\_\_\_\_  
 Physician & #: \_\_\_\_\_  
 Permission for Exam: \_\_\_\_\_  
 Permission for X-ray: \_\_\_\_\_  
 Permission to Photo: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Employer Name: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Employer Name: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the dental office of any changes in contact information & insurance status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_