CREEKSIDE DENTISTRY
IMPROVING YOUR DENTAL EXPERIENCE

Patient Registration

First Name:_____ Last Name:_____ Middle Initial:_____

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

Patient Information:

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

☐ I would like to receive text reminders on my cell phone

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

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail:_____ ☐ I would like to receive email correspondences

Employment Status: O Full Time O Part Time O Self Employed O Retired O Unemployed

Student Status: O Full Time O Part Time

Preferred Dentist:_____ Preferred Hygienist: _____ Preferred Pharmacy:_____

Referred By:_____

Responsible Party: (if someone other than the patient, if unsure leave blank we'll help)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

O Responsible Party is Policy Holder for Patient O Primary Policy Holder O Secondary Policy Holder

Primary Insurance Information: (if none leave blank)

Name of Insured:_____ Relationship to Insured: OSelf OSpouse OChild OOther

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address: _____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information: (if none leave blank)

Name of Insured:_____ Relationship to Insured: OSelf OSpouse OChild OOther

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address: _____

City, State, Zip:_____ City, State, Zip:_____