

**Moore Family Dental PC - PATIENT REGISTRATION**

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

Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired  F/T or P/T Student

Pharmacy – Phone Number - Address: \_\_\_\_\_

Referred By:  Internet  Other Patient  Employer  Other \_\_\_\_\_

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**Responsible Party for Payment:**  SAME AS ABOVE Relationship to patient: \_\_\_\_\_

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

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_

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**Please indicate the method of payment you will use to pay for dental services provided:**

Insurance *(We will prepare and file claim on your behalf.)*  Credit Card  Cash  Personal Check  Care Credit

**Dental Insurance Information:**  Delta Dental  United Concordia  Cigna  Other \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Parent Insurance Company \_\_\_\_\_

Policy/Group# \_\_\_\_\_ Address \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insured Social Security# \_\_\_\_\_ **(Use back if you have SECONDARY Dental**

Insured Birth Date \_\_\_\_\_ **INSURANCE information.)**