

# Claremont Dental Arts

## Patient Registration

### Patient Information

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Email: \_\_\_\_\_  I would like to receive correspondences via email

Emergency Contact Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

---

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

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

---

### Insurance Information

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber/Member ID: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_