SOUTH RIDING
ORAL & IMPLANT
SURGERY

## PATIENT REGISTRATION

**Patient Information:**

Name Preferred Name Date

Address City State Zip Code

Home: ( )____________________ Cell: ( )__________________ Other: ( )__________________

E-mail:_____________________________________________________________________________

Age:______ Birthdate:________________ Sex: ☐ Male ☐ Female

Marital Status:___________________________ Social Security #:________________________

Employment: ☐ Student ☐ Employed ☐ Retired ☐ Other: ________________________

Pharmacy Name:___________________________ Phone: ________________________

Pharmacy Address:_______________________________________________________________

**** TO AVOID DELAYS, WE MUST HAVE YOUR PHARMACY INFO- ALL RX ARE SENT ELECTRONICALLY.**

**Emergency Contact:**

In case of an emergency, whom may we contact?

Name:_________________________ Home: ( )____________________ Cell: ( )__________________

Relationship: _____________________________

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

Name Preferred Name Date

Address City State Zip Code

Home: ( )____________________ Cell: ( )__________________ Other: ( ) __________________

E-mail:_____________________________________________________________________________

Age:______ Birthdate:________________ Sex: ☐ Male ☐ Female

Marital Status:___________________________ Social Security #:________________________

**Primary Dental Insurance:**

_______________________________________________________________________________

Insured Name Date of Birth Relationship to Patient

_______________________________________________________________________________

Insurance Company

Insurance Phone Number: (   )__________________________ Employer: ______________________________

Member ID/ SS#:__________________________________________Group #:__________________________

**Secondary Dental Insurance:**

_______________________________________________________________________________

Insured Name Date of Birth Relationship to Patient

_______________________________________________________________________________

Insurance Company

Insurance Phone Number: (   )__________________________ Employer: ______________________________

Member ID/ SS#:__________________________________________Group #:__________________________

**Health Insurance:**

_______________________________________________________________________________

Insured Name Date of Birth Relationship to Patient

_______________________________________________________________________________

Insurance Company

Insurance Phone Number: (   )__________________________ Employer: ______________________________

Member ID/ SS#:__________________________________________Group #:__________________________

**General Dentist Information:**

Dentist Name:___________________________Phone: (   ) ___________________________________

_______________________________________________________________________________

Address City State Zip Code

_______________________________________________________________________________

Patient or Parent/Guardian Signature Date