CAMDEN HILLS
DENTISTRY

PATIENT REGISTRATION

First Name: ______________________ Last Name: ____________________ Middle Initial: _____

Preferred Name: ____________________________

Patient Information:

Address: _____________________ City, State, Zip: _______________________________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

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

Birth date: ____________________________ Social Security #: ____________________________

E-mail: ________________________________ □ I would like to receive email correspondences

Referred By: ____

Responsible Party: (if someone other than the patient- otherwise leave blank)

First Name: ____________________Last Name: ____________________ Middle Initial: ______

Address: ________________________ Address 2: _______________________

City, State, Zip: ____

Home Phone: ________________ Work Phone: ________________ Cell Phone: ____________________

Birth date: __________________ Social Security #: __________________

Primary Insurance Information:

Name of Insured: _______________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Group ID: _______________________ Carrier ID: _______________________

Insured Social Security #: _________________ Insured Birth date: _______________________

Employer: ____

Insurance Company: ____

Address: ____________________________ City, State, Zip: ____________________________

Phone Number: ____________________________

Person to Contact in Case of an Emergency

Name: ____________________________ Phone: ____________________________

Address: ____