Tom Laster, DDS

Date: ____________

PATIENT REGISTRATION

First Name: ____________ **Last Name:** ____________ **Middle Initial:** ______

Patient Is: ☐ **Policy Holder** **Preferred Name:** ____________

☐ **Responsible Party** **Referred By:** ____________

Patient Information

Address: ____________ Address 2: ____________

City: ____________ State / Zip: ________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext. ____ Cell: ____________

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

Birth Date: ____________ Age: ______ Soc. Sec.: ____________ Drivers Lic. ____________

E-Mail: ____________ ☐ I would like to receive correspondence via e-mail

Occupation: ____________ Employed by: ____________

Student Status: ○ Full Time ○ Part Time

Responsible Party (if someone other than the patient)

First Name: ____________ Last Name: ____________ MI: ______

Address: ____________ Address 2: ____________

City: ____________ State / Zip: ________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext. ____ Cell: ____________

Birth Date: ____________ Soc. Sec.: ____________ Drivers Lic. ____________

○ Responsible Party is also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ____________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc Sec.: ____________ Insured Birth Date: ____________ Insured ID: ____________

Employer: ____________ Plan # ____________ Insurance Co.: ____________

Address: ____________ City, State, Zip: ____________

Phone: ____________

Secondary Insurance Information

Name of Insured: ____________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc Sec.: ____________ Insured Birth Date: ____________ Insured ID: ____________

Employer: ____________ Plan # ____________ Insurance Co.: ____________

Address: ____________ City, State, Zip: ____________

Phone: ____________