Patient Registration

Patient's Name ______________________________ Legal First Name ____________________

Address: ______________________ City ________________ State ________ Zip Code __________

Social Security # ____________ Birth Date: ____________ Sex ________ Full Time Student Yes ___ No ___

Telephone (Home) ________________ (Cell) ____________________ (Work) ________________

E-Mail Address ____

Employed By ____________________ Employer's Address ______________________________

Whom can we thank for referring you to my practice: _________________________________

Spouse's Name __________________ Birth Date ______________ Social Security # ______________

Spouse's Employer: ____________________ Employer's Address _____________________________

Person to notify in case of emergency: Name __________________ Phone # ____________________

Dental Insurance Information

Insured is: ___ Self ___ Spouse ___ Mother ___ Father ___ Significant Other

Employee's Name ____________________ Employee's Social Security Number ____________________

Insurance Co. __________________ Group # __________ ID# __________ Employee's Birth Date ________

Insurance Co. Address ____________________________ Insurance Co. Phone # ________________

Are you covered by a secondary insurance ___ Yes ___ No

If yes Name of 2nd insurance co. ____________________ Address ______________________________
2nd insurance phone # ____________________ Group # ________________ ID# ________________
Employee name for 2nd insurance: ____________________ Social Security # ____________________
Employee's Date of Birth ________________

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Must Complete if Under 18, a Full Time Student or On Parent(s) Insurance, Responsible Party Information Required.

Mother's Name __________________________ Mother's Social Security # ______________________
Address __________________________ City ______________ State ________ Zip __________
Employer ____________________ Occupation ________________ Work # ________________

Father's Name __________________________ Father's Social Security # ______________________
Address __________________________ City ______________ State ________ Zip __________
Employer ____________________ Occupation ________________ Work # ________________

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There is a $4.00 per month charge for all banances which exceed 60 days.

I authorize payment to Dr. Alexander (where applicable) of any Dental Insurance Benefits otherwise payable to me.

X ____ Date: ________________________

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