EUBANKS FAMILY DENTAL

PATIENT REGISTRATION

DATE _____
FULL NAME _____
PREFERRED NAME _____
ADDRESS _____
CITY _____ STATE ___ ZIP _____
PHONE NUMBER _____
EMAIL _____
BIRTHDATE _____
AGE _____ MALE ☐ FEMALE ☐
MARRIED ☐ SINGLE ☐
WIDOWED ☐ DIVORCED ☐
SOCIAL SECURITY _____

PERSON FINANCIALLY RESPONSIBLE
NAME _____
RELATIONSHIP _____
SOCIAL SECURITY _____
ADDRESS _____
CITY _____ STATE ___ ZIP _____

OCCUPATION _____
EMPLOYER _____

IS ANOTHER FAMILY MEMBER A PATIENT OF
THIS OFFICE? YES ☐ NO ☐
RELATIONSHIP _____

YOU WERE REFERRED TO US
BY _____

EMERGENCY CONTACT _____
PHONE NUMBER _____
RELATIONSHIP _____

INSURANCE INFORMATION

PRIMARY CARRIER _____
ADDRESS _____
CITY _____ STATE ___ ZIP _____
PHONE NUMBER _____
SUBSCRIBER NAME _____
RELATIONSHIP TO PATIENT _____
EMPLOYER _____
SUBSCRIBER SS NO. _____
GROUP NO. _____
SUBSCRIBER'S DATE OF BIRTH _____

SECONDARY CARRIER _____
ADDRESS _____
CITY _____ STATE ___ ZIP _____
PHONE NUMBER _____
SUBSCRIBER NAME _____
RELATIONSHIP TO PATIENT _____
EMPLOYER _____
SUBSCRIBER SS NO. _____
GROUP NO. _____
SUBSCRIBER'S DATE OF BIRTH _____