CHRYSALIS DENTAL

PATIENT REGISTRATION

Patient Name: _____ Birth Date: _____--_____--_____

Marital Status: Single Married Widowed

Social Security #: _____--_____--_____ Employer: _____

Cell Phone: _____ -- _____--_____ Email: _____

Address: _____

Responsible Party : ☐ **Self** ☐ **Other (If other, please fill in information below)**

Name:_____ Birth Date: _____--_____--_____ Relationship to Patient: _____

Social Security #: _____--_____--_____ Employer: _____

Cell Phone: _____ -- _____-- _____ Email: _____

Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Insurance Phone#: _____

Insurance ID#: _____ Insurance Group#: _____

SECONDARY INSURANCE INFORMATION

Is there Secondary Coverage? ☐ Yes ☐ No

Name on Secondary Carrier's Insurance: _____Insurer's Birth Date: _____ -- _____ -- _____

Insurer's Social Security #: _____ --_____ -- _____ Isurer's phone #: _____

Insurance Name: _____ Insurance Phone #: _____

Insurance ID#: _____ Insurance Group#: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: _____ Relationship: _____ Phone: _____ -- ____ --_____

REFERRAL (How did you hear about our office?)

☐ Insurance ☐ Internet search ☐ Friends, Family, or Colleague(Who?) _____ ☐ Others: _____

_____ _____

Patient Name (Print) Signature of Patient / Parent & Date