Westside Dental Center

HEALTHY SMILES FOR THE WHOLE FAMILY!

Patient Registration Form

*Please fill out the following information to register - * Required Field*

Patient Information

First Name *

Last Name *

Middle Initial *

Preferred Name

Street Address *

Address (cont.)

City *

State/Province *

Zip/Postal Code *

Home Phone *

Cell Phone

Office Phone

Birth Date *

Social Security Number *

Driver's License Number *

Sex ☐ *Male* ☐ *Female*

Marital Status ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Separated* ☐ *Widow*

Email

Employment Status ☐ *Full-time* ☐ *Part-time* ☐ *Retired*

Employer Name

Street Address

Address (cont.)

City

State/Province

Zip/Postal Code

Rem. Benefits

Rem. Deduct

Student Status ☐ *Full-time* ☐ *Part-time*

Medicaid ID

Employer ID

Carrier ID

Pref. Dentist

Pref. Pharmacy

Pref. Hygienist

Additional Comments

Primary Insurance Information

Name of Insured *

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ☐

Insured Social Security No. *

Insured Birth Date *

Insurance Company *

Street Address *

Address (cont.)

City *

State/Province *

Zip/Postal Code *

Rem. Benefits

Rem. Deduct

Secondary Insurance Information

Name of Insured

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ☐

Insured Social Security No.

Insured Birth Date

Insurance Company

Street Address

Address (cont.)

City

State/Province

Zip/Postal Code

Rem. Benefits

Rem. Deduct

Patient/Guarantor Information

Patient is Policy Holder ☐ Yes ☐ No

Patient is Responsible Party ☐ Yes ☐ No

The responsible party (if other than the patient) please fill out the following

First Name	
Last Name	
Street Address	
Address (cont.)	
City	
State/Province	
Zip/Postal Code	
Home Phone	
Cell Phone	
Office Phone	
Birth Date	
Social Security Number	
Driver's License Number	