SPRING HILL DENTAL ASSOCIATES

Creating beautiful smiles

Patient Registration

First Name: _____ Last Name:_____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone:_____ Cell Phone: _____

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

Birth date:_____ Social Security #:_____ Drivers Lic#: _____

E-mail: _____ Emergency contact info:_____

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Referred By:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer:_____ Insurance Company:_____

Address:_____

City, State, Zip:_____