PATIENT REGISTRATION

Cherry Hills Dental Associates

First Name: _____ Last Name: _____ Middle Initial:_____

Responsible Party

Name:_____
First Middle Last

Address:_____
Apt. #

_____
City State Zip

Cell Phone: _____ Work Phone: _____ Ext:____ Home Phone:_____

Birth Date:_____ **Email:**_____

Soc Sec:_____ Drivers Lic:_____

Sex: Male Female Transgender

Marital Status: Married Single Divorced Separated Widowed

Emergency Contact:_____ **Phone:**_____ Relationship:_____

Who may we thank for referring you?_____

Primary Insurance Information

Policy Holder:_____
First Middle Last

Relationship: Self Spouse Life Partner Child

Insurance Company:_____

Employer: _____

Customer Service/Provider Phone:_____

Group Name:_____ID#:_____Group#_____

Secondary Insurance Information

Policy Holder:_____
First Middle Last

Relationship: Self Spouse Life Partner Child

Insurance Company:_____

Employer: _____

Customer Service/Provider Phone:_____

Group Name:_____ID#:_____Group#_____