Patient Registration

Patient Information

Name: _____ (_____) Social Security #: _____
Last Name First Name Preferred Name

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ E-mail: _____

Preferred contact method: home phone text message email work phone: _____

Sex: Male ☐ Female ☐ Birthdate: _____ Age: _____ Single: ☐ Married: ☐ Widowed: ☐ Separated: ☐ Divorced: ☐

Employer: _____ Occupation: _____

Appointment Time Preference:

Part Time Student: ☐ No Preference: ☐

Prefer AM: ☐

Name of School (If Patient Is A Student): _____ Full Time Student: ☐ Prefer PM: ☐

Emergency Contact: _____ Phone: _____

How did you hear about us or who may we thank for referring you? _____

Primary Dental Insurance

Policy Holder: _____ _____ _____ _____
Last Name First Name **Date of Birth** Relationship to Patient

Address (if different from patient): _____ _____ _____ _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ _____ _____ Business Phone: _____
City State Zip

Insurance Company: _____ **SS or ID#:** _____ **Group #:** _____

Additional family members under this plan: _____

Additional Dental Insurance

Policy Holder: _____ _____ _____ _____
Last Name First Name **Date of Birth** Relationship to Patient:

Address (if different from patient): _____ _____ _____ _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ _____ _____ Business Phone: _____
City State Zip

Insurance Company: _____ **ID/SS #:** _____ Group #: _____

Additional family members under this plan: _____

I certify that the above information is true and correct to the best of my knowledge.
I agree to notify Glacier Lake Dental of any changes in the above information and/or my health status.

X _____ _____
Signature of Patient, Parent or Guardian Date