Serenity Dental

Patient Registration

First Name:_____ Last Name:_____ Date:_____
Patient is: ___Policy Holder Preferred Name:_____
___Responsible Party

Responsible Party (if someone other than the patient)
First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

Birth Date:_____ Soc Sec:_____Drivers Lic:_____

__Responsible Party is also a Policy Holder for Patient ___Primary Insurance Policy Holder ___Secondary Insurance Policy Holder

Patient Information
Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

Birth Date:_____ Age:_____ Soc Sec:_____Drivers Lic:_____

Sex: _____Male ____Female Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

I would like to receive correspondences via email: ___Yes ___No Email:_____

Section 2 Section 3

Employment Status: ___Full Time ___Part Time ___Retired
Student Status: ___Full Time ___Part Time

Previous Dentist:_____
Emergency Contact#:_____
ReferredBy:_____

Medicaid ID:_____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hygienist:_____

Primary Insurance Information
Name of Insured:_____ Relationship to Insured: ___Self ___Spouse ___Child ___Other

Insured Soc. Sec:_____ Insured Birth Date:_____

Employer:_____ Insurance Company: _____

Address:_____ Insurance Address:_____

Address 2:_____ Insurance Address 2: _____

City, State, Zip:_____ Ins. City, State, Zip:_____

Rem. Benefits:_____ Rem. Deductable:_____

Secondary Insurance Information
Name of Insured:_____ Relationship to Insured: ___Self ___Spouse ___Child ___Other

Insured Soc. Sec:_____ Insured Birth Date:_____

Employer:_____ Insurance Company: _____

Address:_____ Insurance Address:_____

Address 2:_____ Insurance Address 2: _____

City, State, Zip:_____ Ins. City, State, Zip:_____

Rem. Benefits:_____ Rem. Deductable:_____