PATIENT REGISTRATION

SUNRISE DENTAL
www.sunrisedental.com

ID: _____ Chart ID:_____

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

Patient is: ❑ Policy Holder ❑ Responsible Party Preferred Name:_____

Responsible Party (if someone other than the patient)

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

Address:_____Address 2:_____

City, State, Zip:_____ Pager:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

Birth Date:_____Soc. Sec:_____Driver's 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:_____Pager:_____

Home Phone:_____Work Phone:_____Ext:_____Cellular:_____

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

Birth Date:_____Soc. Sec:_____Driver's Lic:_____

E-mail:_____ ❑ I would like to receive correspondences via email

SECTION 2

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

Student Status: ❑ Full Time ❑ Part Time

Medicaid ID:_____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg.:_____

SECTION 3 - Referral Source:

PRIMARY INSURANCE INFORMATION

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

Insured Soc. Sec:_____Insured Birth Date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Benefits:_____.00 Rem. Deduct:_____00

SECONDARY INSURANCE INFORMATION

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

Insured Soc. Sec:_____Insured Birth Date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Benefits:_____.00 Rem. Deduct:_____00