

Thomas J. Gilbert D.D.S. P.C.

**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Date \_\_\_\_\_ How did you here of our office? Existing Patient \_\_\_\_\_ (name)

Insurance Website \_\_\_\_\_ Internet \_\_\_\_\_ Drive by \_\_\_\_\_ Other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone # if different than home: \_\_\_\_\_  I would like to receive text messages

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Email address: \_\_\_\_\_  I would like to receive email messages

Sex: \_\_\_ Female \_\_\_ Male Marital status: S M D W

Employment status \_\_\_ full-time \_\_\_ part-time \_\_\_ retired \_\_\_ student (School and City) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY (if someone other than patient)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell Phone # if different than home: \_\_\_\_\_ I would like to receive text messages: Y/N

Birthdate : \_\_\_\_\_ SSN: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Email address: \_\_\_\_\_ I would like to receive email messages: Y/N

Sex: \_\_\_ Female \_\_\_ Male Marital status: S M D W

Employment status \_\_\_ full-time \_\_\_ part-time \_\_\_ retired \_\_\_ student (School and City) \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**SECONDARY INSURANCE INFORMATION**

Name of insured \_\_\_\_\_

Name of insured \_\_\_\_\_

Relationship to insured \_\_\_\_\_

Relationship to insured \_\_\_\_\_

Insured SSN \_\_\_\_\_

Insured SSN \_\_\_\_\_

Insured Birthdate \_\_\_\_\_

Insured Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Insurance \_\_\_\_\_

Insurance \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_

City, State \_\_\_\_\_