

# Westhaven

## Family and Cosmetic Dentistry

### Patient Registration

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: \_\_\_\_\_ 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: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cellular: \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
 Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 E-mail \_\_\_\_\_  I would prefer not to receive correspondences or reminders via e-mail.

Employment Status:  Full  Part Time  Retired  
 Student Status:  Full  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Insurance Group # \_\_\_\_\_  
 Prev. Dentist Name: \_\_\_\_\_  
 Referred By: \_\_\_\_\_  
 Pre-Medication: \_\_\_\_\_

Primary Insurance Information  
 Name of Insured: \_\_\_\_\_ Relationship to Insured :  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 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: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

Ins. Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

Rem. Benefits: \$ \_\_\_\_\_ .00 Rem. Deduct: \$ \_\_\_\_\_ .00