

# PATIENT REGISTRATION

## PATIENT INFORMATION

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

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_

E-mail: \_\_\_\_\_

Responsible Party (if someone other than the patient):

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

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_

Referral Source: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

**SUNRISE DENTAL**

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