LEGACY DENTAL

Patient Registration

First name:_____ Last Name:_____ M.I._____

Address:_____

Home phone:_____ Cell phone:_____ Work phone:_____

Date of Birth:_____ Social Security #:_____ Sex: Male/Female

Marital Status:_____ E-mail:_____

May we contact you via E-mail? Yes/No
May we contact you via text-message? Yes/No

Is the patient : The Primary Insurance Policy Holder? Yes/No
The Secondary Insurance Policy Holder? Yes/No
The Financially Responsible Party? Yes/No

If patient is a student, are they full time or part time? _____

If you are not the Financially Responsible Party, may we discuss your financial and treatment information with the Financially Responsible Party? Yes/No

---

If the patient is **not** the Financially Responsible Party, please complete the following section regarding the Financially Responsible Party:

First name:_____ Last Name:_____ M.I._____

Address:_____

Home phone:_____ Cell phone:_____ Work phone:_____

Date of Birth:_____ Social Security #:_____

Relationship to the Insured: Spouse Child Other:_____

Is the Financially Responsible Party: The Policy Holder for the patient? Yes/No
The Primary Insurance Policy Holder? Yes/No
The Secondary Insurance Policy Holder? Yes/No

OVER

Primary Insurance Information:

Name of insured:_____ Relationship to Insured: Self Spouse Child

Insured Soc. Sec.:_____ Insured Date of Birth:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Rem Benefits:_____Rem Deduct:_____

Secondary Insurance Information:

Name of insured:_____ Relationship to Insured: Self Spouse Child

Insured Soc. Sec.:_____ Insured Date of Birth:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Rem Benefits:_____Rem Deduct:_____