



Bronson Dental

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Clinton, Utah 84015 · 801.728.3924

Patient Registration

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

Patient is: Insurance Policy Holder
 Person Responsible for any Billing issues

Person Responsible for any Billing issues (complete only if person responsible is someone other than the patient):

First Name: _____ Middle Initial: _____ Last Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Cellular: _____ Birth Date: _____ Soc. Sec: _____ Drivers License: _____ Is this person also the Policy Holder for the Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes: <input type="checkbox"/> Primary or <input type="checkbox"/> Secondary

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Birth Date: _____ Soc. Sec: _____ Drivers License: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Statue: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Insured Soc. Sec: _____ Insured Birth Date: _____ Employer: _____ Insurance ID #: _____ Employer Address: _____ City, State, Zip: _____ Insurance Company: _____ Insurance Company Address: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Insured Soc. Sec: _____ Insured Birth Date: _____ Employer: _____ Insurance ID #: _____ Employer Address: _____ City, State, Zip: _____ Insurance Company: _____ Insurance Company Address: _____ City, State, Zip: _____

How did you hear about our office? Insurance Advertisement Friend: _____