SAN JUAN DENTAL CENTER

13630 Veterans Memorial Dr. Suite H Houston, TX 77014 Tel: 281-631-9200

Patient Registration

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial _____

Preferred Name: _____ Patient is: ☐ Policy Holder ☐Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial _____

Address: _____ Address 2: _____

City, State, ZIP: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellphone: _____

Birth Date: _____(mm/dd/yy) Social Security: _____ Driver's License: _____

E-mail: _____

☐ 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: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellphone: _____

Sex: ☐ Male ☐Female Marital Status: ☐ Married ☐ Single ☐ Divorce ☐Separated ☐ Widowed

Birth Date: _____(mm/dd/yy) Social Security: _____ Driver's License: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

-- Section 2 --

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

-- Section 3 --

Referred By: _____

Previous Dentist: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, ZIP: _____ 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: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, ZIP: _____ City, State, ZIP: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Address: 13630 Veterans Memorial Dr., Suite H, Houston TX, 77014
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