CACHE VALLEY
WISDOM TEETH

Patient Registration

Date:_____

Patient Information:

First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: Male Female _____ Birth Date _____ Age _____ Email_____

Address _____ City _____State _____ Zip _____

Home Tel. (____)_____Cell (____)_____ SSN: _____

How did you hear about our office?_____

Emergency Contact_____ Relationship_____ Phone_____

Has a family member or friend ever been a patient of our practice? Yes No If yes, who? _____

Who will be responsible for your account?

Circle One: Self Spouse Father Mother Other

(If self, skip to next section) Birth Date _____ SSN: _____

First Name_____ Last Name_____ Phone_____

Address _____ City _____ State _____ Zip _____

Insurance Information:

NO INSURANCE ☐

Primary Insurance Company Name_____ Employer_____

Member ID Number_____

Policy Holder Name_____ Birth Date_____ Relationship_____

Secondary Insurance Company Name_____ Employer_____

Member ID Number _____

Policy Holder Name_____ Birth Date_____ Relationship_____