Unique Dental Care, PLLC
13181 Old Nashville Hwy, Suite 110
Smyrna, TN 37167

PATIENT REGISTRATION

ID: _____ Chart ID: _____ **How did you hear about our office?** _____

First Name: _____ Last Name: _____ Middle Int: _____

Preferred Name: _____

Address: _____ Address 2: _____
(If address is a P.O. Box, please include your street address as address 2)

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____ State _____

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

Employment Status: ○ Full Time ○ Part Time ○ Retired

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

Student Status: ○ Full Time ○ Part Time School: _____

Preferred Pharmacy: _____

Is patient the responsible party? ☐ Yes ☐ No

Responsible Party: (If patient is responsible party, you do not have to fill this section out)

First Name: _____ Last Name: _____ Middle Int: _____

Address: _____ Address 2: _____
(If address is a P.O. Box, please include your street address as address 2)

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____ State _____

Is responsible party, policy holder for patient? ☐ Yes ☐ No

Primary Insurance Information:

Name of Insured: _____ Relationship to patient: ○ Self ○ Spouse ○ Parent ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member #: _____
(If different from Soc. Sec. Number)

Insurance Company: _____ Group #: _____

Address: _____

City, State, Zip: _____

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to patient: ○ Self ○ Spouse ○ Parent ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member #: _____
(If different from Soc. Sec. Number)

Insurance Company: _____ Group #: _____

Address: _____

City, State, Zip: _____

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____