**PATIENT REGISTRATION**

**Patient Information**

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

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone_____ Work Phone: _____ Cellular: _____

Gender _ Male _Female _Other Marital Status _Married _Single _Divorced _Separated _Widowed

Birthdate: _____ Age: _____ Soc. Sec: _____

E-mail: _____

**Responsible Party (if someone other than patient)**

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

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birthdate: _____ Age: _____ Soc. Sec: _____

_ Responsible Party is also a Policy Holder for Patient _Primary Insurance policy Holder _Secondary policy holder

Your Employment Status _ Full Time _ Part Time _ Retired _Other Student Status _ Full Time _ Part Time

Emergency Contact: _____ Contact Phone Number: _____

Who may we thank for referring you to our office? _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other (circle one)

Insured Identification Number: _____ Group Number: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____

Address: _____City, State, Zip _____

**PATIENT REGISTRATION**

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other (circle one)

Insured Identification Number: _____ Group Number: _____ Date of Birth: _____

Employer: _____ Insurance Company_____

Address: _____ City, State, Zip_____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or phone number. I would like the office to contact me regarding:

(INITIAL BELOW)

_ text correspondence

_ email correspondence

_ Appointment Reminders/Recall Visits

_Information regarding insurance/billing

_Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communication at any time by contacting:

Cambridgeside Dental Associates, 617-491-1403, info@cambridgesidedental.com