CHARLOTTESVILLE BLUE RIDGE DENTAL
Patient Registration

Patient Information

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

Date of Birth: _____ Gender: ○ Male ○ Female SSN: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ (○Home ○Work ○Cell) Alternate: _____ (○Home ○Work ○Cell)

Reason for Visit: _____

Date of Last Dental Visit: _____ Date of Last Cleaning: _____

How did you hear about us? _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Insurance Information

○ I have no insurance (please skip to next section, "Financial Information") Relationship to policy holder: ○Self ○Spouse ○Child ○Other

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Soc Sec: _____ Insurance Company: _____

Group Number: _____ ID Number: _____ Employer: _____

Do you have a secondary insurance policy? ○ Yes ○ No

Financial Information

Is the patient the responsible party? ○ Yes ○ No If the answer is no, please provide the responsible party's information

Responsible Party First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____ Soc Sec: _____

Home Phone: _____ Cell: _____ Work: _____ Birth Date: _____

I would like to receive correspondence such as appointment reminders via:

○ Text Message (please make sure we have your cell phone number listed in the first section)

○ E-mail: _____