Silva Family Dentistry
Center for Dental Implants and Facial Esthetics

Patient Registration Form

Patient Information

First Name	MI	Last Name		
◯ Male ◯ Female ◯ Non-binary	◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed			
Date of Birth	Social Security Number			
Mailing Address	City	State	Zip	
Secondary Mailing Address	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
E-mail	◯ Opt in for E-mail communication	◯ Opt in for text communication		

Responsible Party Information (Who is financially responsible for the account)

☐ **Same as Patient**

First Name	MI	Last Name		
Mailing Address	City	State	Zip	
Secondary Mailing Address	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
E-mail	◯ Opt in for E-mail communication	◯ Opt in for text communication		

Primary Dental Insurance (Please complete this information for the Policy Holder)

☐ **Same as Patient**

First Name	MI	Last Name		
Date of Birth	Social Security Number	Phone Number		
Employer	Insurance Company			
Group Number	Subscriber ID			
Insurance Company Mailing Address	City	State	Zip	
Insurance Phone Number	Patient Relationship to Policy Holder ◯ Self ◯ Spouse ◯ Child ◯ Other			

Secondary Dental Insurance (Please complete this information for the Policy Holder)

☐ **Same as Patient**

First Name	MI	Last Name		
Date of Birth	Social Security Number	Phone Number		
Employer	Insurance Company			
Group Number	Subscriber ID			
Insurance Company Mailing Address	City	State	Zip	
Insurance Phone Number	Patient Relationship to Policy Holder ◯ Self ◯ Spouse ◯ Child ◯ Other			