NSU NOVA SOUTHEASTERN UNIVERSITY
Dental Clinics

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| Patient Last Name | Legal First Name | Middle | ☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss ☐ Rev. |
|---|---|---|---|

| Maiden Name | Preferred First Name | Date of Birth | Age | Gender: ☐ Male ☐ Female ☐ Other_____ |
|---|---|---|---|---|

| Street Address | Apt No. | Home phone # |
|---|---|---|

| City | State | Zip Code | Social Security # | Cell phone # |
|---|---|---|---|---|

| Employer Name and Address | Occupation | Work phone # |
|---|---|---|

| Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ French ☐ Other_____ | Preferred contact # ☐ Home ☐ Cell ☐ Work ☐ Other_____ |
|---|---|---|

| E-Mail Address | Check if you do NOT want to receive communications from NSU-CDM at your email address. (Examples: Appointment Reminders, Patient Surveys, Administrative Updates) ☐ Opt Out |
|---|---|

| Race: ☐ Asian ☐ Black or African American ☐ White ☐ Multi-racial ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander | Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino | Are you or any family member a veteran or current member of the Armed Services? ☐ YES ☐ NO |
|---|---|---|

| Emergency Contact | Relationship to Patient | Contact Phone # | Primary Care Physician Phone # |
|---|---|---|---|

## RESPONSIBLE PARTY/GUARANTOR

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:

**For minor (under 18), dependant, or Guarantor other than Patient:**

| Last Name | First Name | Middle | ☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss ☐ Rev. |
|---|---|---|---|

| Street Address | Apt No. | Contact Phone # ☐ Home ☐ Cell |
|---|---|---|

| City | State | Zip Code | Date of Birth | ID/Driver License # State |
|---|---|---|---|---|

| Employer Name and Address | Occupation | Work phone # |
|---|---|---|

## SPOUSE OR SECOND PARENT INFORMATION

| Last Name | First Name | Middle | ☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss ☐ Rev. |
|---|---|---|---|

| Street Address | Apt No. | Contact Phone # ☐ Home ☐ Cell |
|---|---|---|

| City | State | Zip Code | Date of Birth | ID/Driver License # State |
|---|---|---|---|---|

| Employer Name and Address | Occupation | Work phone # |
|---|---|---|

## DENTAL INSURANCE INFORMATION

| Name of Insured | Date of Birth | Insured's Soc. Security # | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other |
|---|---|---|---|

| Insurance Co. | ID # | Group # | Ins. Co. Phone # |
|---|---|---|---|

*HOW DID YOU HEAR ABOUT US?*

☐ Friend or Relative ☐ NSU-CDM referral line ☐ NSU-CDM website ☐ Billboard ☐ Insurance Provider List ☐ Newspaper ☐ Community Event/Lecture

☐ Physician/Dentist referral_____ ☐ Emergency Room_____ ☐ Other_____

**I hereby declare that the above information is correct and complete.**

**PATIENT/RESPONSIBLE PARTY SIGNATURE**_____ **DATE**_____