Evan G. Young, DDS, Midnight Sun Smiles, LLC 2000 Abbott Rd, Suite 100, Anchorage, Ak, 99507

# PATIENT REGISTRATION

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

Patient is:□□□Insurance Policy Holder□□□□Responsible Party (Check as applicable) Preferred Name: _____

## Patient Information – Patient Section One

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Ext_____

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

Birth Date:_____ Age:_____ Social Security No._____ Driver's License No._____

E-mail Address:_____ □ I would like to receive correspondence via-email

## Patient Section Two

Employment Status: □ Full Time □ Part Time □ Retired: Employer:_____

Student Status: □ Full Time □ Part Time □

Preferred Hygienist: □ Ellen□□ Hannah□□ No Preference

Preferred Pharmacy:_____

Who may we thank for referring you? _____

## Patient Section Three

**Right to Privacy:** May we share your health information with your spouse or a designated party? If yes, please complete the section below:

Name_____

Relationship _____

Phone # _____

Email _____

## Responsible Party (if someone other than patient)

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

Address:_____ Address 2:_____

City, State, Zip:_____ Pager:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____ Ext_____

Driver's License No: _____ Date of Birth:_____ Social Security No:_____

□ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Policy Holder (OR) □ Secondary Insurance Policy Holder

## Primary Insurance Information

Individual with insurance policy_____ Birth Date_____ SSN_____

Individual's relationship to the patient: □ I am the patient□□□ I am the patient's spouse□□□ I am the patient's parent/guardian□□□ Other

Employer_____ Insurance Company_____

Address_____ Address_____

Address 2_____ City, State, Zip_____

City, State, Zip_____ Policy ID #_____ Group #_____

## Secondary Insurance Information

Individual with insurance policy_____ Birth Date_____ SSN_____

Individual's relationship to the patient: □ I am the patient□□□ I am the patient's spouse□□□ I am the patient's parent/guardian□□□ Other

Employer_____ Insurance Company_____

Address_____ Address_____

Address 2_____ City, State, Zip_____

City, State, Zip_____ Policy ID #_____ Group #_____