

The Hygiene Center, LLC

1316 Jackie Rd SE #200 Rio Rancho, NM 87124 Phone 505-994-9693 Fax 505-891-3169

PATIENT REGISTRATION

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

Preferred Name: _____ Date of Birth: _____ Soc. Sec.# _____ *(required for insurance)*

Gender: Male: ___ Female: ___ Marital Status: Married: ___ Single: ___ Divorced: ___ Separated: ___ Widowed: ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work#: _____

Cell Phone Service Provider: _____ Email: _____

Emergency Contact Name: _____ Phone Number: _____

Referred By: _____ Previous Dentist: _____ Phone Number: _____

Responsible Party, If someone other than the Patient

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

Preferred Name: _____ Date of Birth: _____ Soc. Sec.# _____ *(required for insurance)*

Gender: Male: ___ Female: ___ Marital Status: Married: ___ Single: ___ Divorced: ___ Separated: ___ Widowed: ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work#: _____

Cell Phone Service Provider: _____ Email: _____

Primary Insurance Information

Name of Insured: _____ Soc. Sec.# _____ *(required for insurance)*

Date of Birth: _____ Relationship to Patient: Self: ___ Spouse: ___ Child: ___ Other: ___

Employer: _____ Insurance Company: _____

Carrier ID: _____ Member ID: _____

Insurance Address: _____ City: _____ State _____ Zip: _____

Secondary Insurance Information

Name of Insured: _____ Soc. Sec.# _____ *(required for insurance)*

Date of Birth: _____ Relationship to Patient: Self: ___ Spouse: ___ Child: ___ Other: ___

Employer: _____ Insurance Company: _____

Carrier ID: _____ Member ID: _____

Insurance Address: _____ City: _____ State _____ Zip: _____