ORANGE TREE
ORAL SURGERY & IMPLANT CENTER

Patient Registration

Name: _____
Last First Middle

Date of Birth: _____ Sex □ M or □ F

Social Security # (Needed to verify insurance): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone #: _____

Can we text you regarding appointment? □ Y / □ N

Occupation: _____ Employer: _____

How did you hear about us? _____ Referred by: _____

If a patient is a minor:

Mother's DOB: _____ Father's DOB: _____

Name of Parent: _____ Parent Social Security #: _____

Relationship to the patient: _____

Parent Employer _____ Parent Phone # _____

Insurance Policy Primary

Relationship to Subscriber: □ Self / □ Spouse / □ Child

Subscriber Name: _____ Subscriber ID#: _____ Subscriber DOB: _____

Insurance Company: _____ Ins Phone #: _____

Employer: _____ Group Name: _____ Group #: _____

Insurance Policy Secondary (If applicable)

Relationship to Subscriber: □ Self / □ Spouse / □ Child

Subscriber Name: _____ Subscriber ID#: _____ Subscriber DOB: _____

Insurance Company: _____ Ins Phone #: _____

Employer: _____ Group Name: _____ Group #: _____