Evan G. Young, DDS, dba Midnight Sun Smiles, LLC 2000 Abbott Road 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:_____

Responsible Party (if someone other than the patient)

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

Address:_____ Address 2:_____

City, State, Zip:_____ Pager :_____

Home Phone:_____ Work Phone:_____ Ext.:_____ Cell Phone:_____

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

❑ Responsible Party is also a Policy Holder for Patient ⇨ ❑ Primary Insurance Policy Holder or ❑ Secondary Insurance Policy Holder

Patient Information – Patient Section One

Address:_____ Address 2:_____

City, State, Zip:_____ Pager :_____

Home Phone:_____ Work Phone:_____ Ext.:_____ Cell Phone:_____

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

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

E-Mail Address:_____ ❑ I would like to receive correspondence via e-mail

Patient Section Two

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired; Employer:_____

Student Status: ❑ Full Time ❑ Part Time

Pref.Dentist: ❑ Dr. Young ❑ Dr. Marlin ❑ Either

Pref Hygienist: ❑ Amanda ❑ Elpida ❑ Either

Pref Pharmacy:_____

Patient Section Three

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

Name:_____
Relationship:_____
Phone:_____
Email:_____

Primary Insurance Information

Name of Person with Insurance Policy:_____ Birth date:_____ SSN:_____

This person's relationship to the patient: ❑ I am the Patient ❑ I am 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

Name of Person with Insurance Policy:_____ Birth date:_____ SSN:_____

This person's relationship to the patient: ❑ I am the Patient ❑ I am 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 #:_____