

**Cameron G. Francis, DDS**  
**2410 W. University Drive**  
**McKinney, TX 75071**  
**972-562-0228**

**PATIENT REGISTRATION**

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

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

Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

**RESPONSIBLE PARTY: (If someone other than patient)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Name of Member: \_\_\_\_\_ Member SS#: \_\_\_\_\_

Member Date of birth: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_