PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

# PATIENT REGISTRATION

## PLEASE PRINT PATIENT'S INFORMATION BELOW

NAME _____ PREFERS TO BE CALLED _____
First MI Last

ADDRESS _____ HOME PHONE _____
Street City State Zip

CELL PHONE _____ EMAIL _____

HOW DO YOU PREFER TO RECEIVE APPOINTMENT REMINDERS? (Please circle all that apply) PHONE EMAIL TEXT

BIRTHDATE _____ AGE _____ SOCIAL SECURITY NO. _____ - _____ - _____

GENDER: MALE FEMALE MARITAL STATUS (Please choose one): MARRIED SINGLE DIVORCED WIDOWED

OCCUPATION _____ EMPLOYER'S NAME _____ WORK PHONE _____

WORK ADDRESS _____ OK TO CALL WORK? YES NO
Street City State Zip

## HOW DID YOU HEAR ABOUT OUR OFFICE? (Please circle all that apply)

WKZO WVFM – 106.5 GOOGLE SEARCH – WHAT DID YOU SEARCH FOR? _____

FACEBOOK WOMEN'S LIFESTYLE SPARK PORTAGE LIVING SPECIFIC EVENT _____

PERSONAL REFERRAL _____ OTHER _____

Ask us about our referral program!

## GETTING TO KNOW YOU

DO YOU HAVE A FAMILY MEMBER WHO IS A PATIENT AT OUR OFFICE? (Please circle one) YES NO

NAME _____ RELATIONSHIP _____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME _____ RELATIONSHIP _____ PHONE _____

## DENTAL INSURANCE

INSURANCE COVERAGE? YES NO SECONDARY COVERAGE? YES NO

PRIMARY INSURANCE COMPANY INFORMATION

NAME _____
PHONE # _____
SUBSCRIBER/MEMBER ID # _____
GROUP # _____

SECONDARY INSURANCE COMPANY INFORMATION

NAME _____
PHONE # _____
SUBSCRIBER/MEMBER ID # _____
GROUP # _____

SUBSCRIBER'S INFORMATION

SUBSCRIBER'S NAME _____
EMPLOYER'S NAME _____
SUBSCRIBER'S DATE OF BIRTH _____
SUBSCRIBER'S SOCIAL SECURITY # _____

SUBSCRIBER'S NAME _____
EMPLOYER'S NAME _____
SUBSCRIBER'S DATE OF BIRTH _____
SUBSCRIBER'S SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER

SELF SPOUSE DEPENDENT

PATIENT'S RELATIONSHIP TO SUBSCRIBER

SELF SPOUSE DEPENDENT

*Your Smile is Our Passion™*

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