Associates in Family Dentistry
Patient Registration

Patient's First Name: _____ Last Name: _____ Middle Initial: ___
Patient's address: _____ PO Box_____
City: _____ State/Zip _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Age: _____ SS# _____ Patient's Employer: _____
Sex: ___ Male ___ Female
Marital Status: (circle one) Married Single Divorced Separated Widowed

Email: _____ I would like to receive correspondence by email: Y N

PERSON RESPONSIBLE FOR PAYING BILL:_____
City/State/Zip: _____ Home phone_____
Cell Phone: _____ Work Phone: _____ Ext: _____

STUDENT STATUS, if over age 18: Full Time ___ Part Time ___ N/A ___
Name and Address of School: _____

Do other family members come here? Names: _____
EMERGENCY CONTACT: Name_____ Ph #_____Relationship_____
WHO MAY WE THANK FOR REFERRING YOU? ___

Primary Dental Insurance:

Name & Address of SUBSCRIBER: _____
Relationship to Patient: Self ___ Spouse ___ Child ___ Other ___
INSURED SUBSCRIBER'S SS# or ID #: _____ ___ D.O.B._____
_____
Employer Name and Address: _____
Ins. Company: _____
Group # _____ Ins. Phone # _____
I AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO ASSOCIATES IN FAMILY DENTISTRY AND THAT ANY BALANCE REMAINING AFTER MY INSURANCE HAS PAID IS MY RESPONSIBILITY _____

Secondary Dental Insurance:

Name of Insured: _____
Relationship to Patient: Self ___ Spouse ___ Child ___ Other ___
Insured Soc. Sec: _____ Insured Birth Date _____
Employer Name and Address:_____ _____
Ins. Company: _____
Group # _____ Ins. Phone # _____

Thank you for choosing Associates In Family Dentistry!