Patient Registration

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Patient Information

Patient Name_____ Birthdate____/_____/_____ Age_____

First MI Last Male ☐ Female ☐

Address_____ City, State, Zip_____

Email_____ Employer_____

Home Phone # (____)_____ Work # (____)_____ Cell # (____)_____

Social Security Number_____-_____-_____ U.S. Citizen Yes No Driver's license #_____ State_____

Person to contact if unable to reach you directly or in an emergency:

Name of Friend or Relative _____ Relationship_____

Address_____ City, State, Zip_____

Phone (____)_____

From whom or how did you hear about our office?_____

Person Responsible for Account

Please complete this section if other than the above person.

Patient Name_____ Birthdate____/_____/_____ Age_____

First MI Last Male Female

Please circle one: Self Father Mother Wife Husband Guardian

Address_____ City, State, Zip_____

Employer_____ Social Security Number _____-_____-_____

Home Phone # (____)_____ Work # (____)_____ Cell # (____)_____

Primary Insurance Information

Insurance Company_____

Company Address_____

City, State, Zip_____

Company phone number (_____)_____

Group number_____

ID number_____

Name of Policy Holder_____

Secondary Insurance Information

Insurance Company_____

Company Address_____

City, State, Zip_____

Company phone number (_____)_____

Group number_____

ID number_____

Name of Policy Holder_____

I HEREBY AUTHORIZE DENTAL INSURANCE BENEFIT PAYMENT BE MADE DIRECTLY TO **SCOTT K. NICHOLSON**, DMD, OTHERWISE PAYABLE TO ME.

Insured's signature _____ Date _____