BERRIEN DENTAL PATIENT REGISTRATION

FIRST NAME_______________________________________ **LAST NAME**____ **MIDDLE INITIAL** ___

Preferred Name__________________________________ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Birth Date______________________________ Soc. Sec___________________________________ Drivers Lic_____________________________________

Address____ Address 2 ____

(IF ADDRESS IS A P.O. BOX, PLEASE INCLUDE STREET ADDRESS AS ADDRESS 2)

City, State, Zip____

Home Phone____ Work Phone____ Ext_________________

Cell____ Email address____

Employer ____ Employer's telephone____

Employer's address ____City__________________________________State_______Zip____________

Emergency contact person, **NOT LIVING WITH YOU?** ____Phone___________________________

If patient is a student, please complete:

Name of School____ Full Time ☐ Part Time ☐

RESPONSIBLE PARTY INFORMATION

FIRST NAME_______________________________________**LAST NAME**____**Sex:** ☐ M ☐ F

Birth Date______________________________ Soc. Sec____________________________ ______Drivers Lic_____________________________________

Address____ Address 2 ____

(IF ADDRESS IS A P.O. BOX, PLEASE INCLUDE STREET ADDRESS AS ADDRESS 2) Relationship to Patient________________________

City, State, Zip____

Home Phone____Work Phone____ Ext________________

Cell____Email address____

Employer _____________________________________ ____________________Employer's telephone____

Employer's address ____City__________________________________State_______Zip____________

SPOUSE____ _____Work Phone_____________________________________ Ext_____________

Birth Date________________________________Soc. Sec_______________________________________Relationship to Patient______________________

Employer _____________________________________ __________________ ____Employer's telephone____

Employer's address ____City________________________________State________Zip___________

DENTAL INSURANCE INFORMATION

Primary Insurance Co. ____Phone ___________________________________

Insurance Co. Address____City__________________________State______________Zip_______

ID #____ ___ Group # ____

Policy Holder's Name____Birthdate__________________Relationship to patient ______________

Address____City_________________________State______________Zip________

Is Insurance through employer? __________If yes, list employer____

Secondary Insurance Co.____Phone_____________________________________

Insurance Co. Address____City__________________________State______________Zip_______

ID #____ ___ Group # ____

Policy Holder's Name____Birthdate__________________Relationship to patient ______________

Address____City_________________________State______________Zip________

Is Insurance through employer?__________If yes, list employer____