Grace Dentistry, LLC

PATIENT REGISTRATION

Date:_____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name:_____

Patient Information

Address: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

It is best to reach me via my: ◯ home phone ◯ work phone ◯ cellular ◯ pager ◯ e-mail

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

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Employer: _____

Student Status: ◯ Full Time ◯ Part Time

School:_____

Section 3

Emergency Contact: _____

Home Phone:_____

Work Phone: _____ ext: _____

Cellular:_____ Pager: _____

Referral

Whom may we thank for referring you to our practice? _____

◯ Welcome Wagon/Neighbor ◯ Yellow Pages ◯ internet ◯ Dr. _____ ◯ other_____

Responsible Party

☐ Check here if patient is also the responsible party and skip to the next section.

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insurance ID # _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City,State,Zip: _____ City,State,Zip: _____

Phone : _____ Phone : _____

Annual Benefit Maximum: _____ Annual Individual Deductible: _____ Annual Family Deductible: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insurance ID # _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City,State,Zip: _____ City,State,Zip: _____

Phone : _____ Phone : _____

Annual Benefit Maximum: _____ Annual Individual Deductible: _____ Annual Family Deductible: _____