Rydell FAMILY DENTAL

PATIENT REGISTRATION

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

Preferred Name:_____

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

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

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: ○ Female ○ Male

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail:_____ □ I would like to receive email correspondences

Preferred Hygienist:_____ Preferred Pharmacy:_____

Primary Insurance Information:

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

Member ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:

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

Member ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____