Edelweiss Dental Implant Center **PATIENT**

REGISTRATION

May, 2016

PATIENT NAME:________________________________ ___________ ____________________________

FIRST MIDDLE Initial LAST

ADDRESS: ________________________________ __________ ______________________ _________ ________________

NUMBER / STREET APPT # CITY STATE ZIP

PHONE : HOME _________________________ **CELL:** ______________________________ **WORK** _____________________

BIRTHDATE: _________/__________/_____ _____ **SOCIAL SEC #** ____

EMAIL: ____ **I Would like to receive correspondences via e-mail**

CHECK APPROPRIATE BOXES: MINOR SINGLE MARRIED Is patient: Policy Holder Responsible Party

WHO IS THE RESPONSIBLE PARTY FOR PAYMENT OF THIS ACCOUNT: ____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER ___________________________

SPOUSE (OR PARENT/GUARDIAN) NAME: ___________________________ __________ _________________________

FIRST MIDDLE Initial LAST

CONTACT PHONE # FOR SPOUSE/GUARDIAN: ______________________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY: ______________________________________ **PHONE:** _________________

RELATIONSHIP: SPOUSE PARENT OTHER _____________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE? :

other:____

Online search Our Website Drive by Patient Referred: **name** _________________________

DENTAL INSURANCE INFORMATION

NAME OF INSURED (IF OTHER THAN PATIENT):

____ ____________ ____

FIRST MIDDLE Initial LAST

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER ______________________

EMPLOYER: ____ WORK PHONE: ____________________________________

MEMBER ID #: ____ GROUP #: ____

INSURANCE COMPANY NAME: ____ PHONE # : __________________________________

INSURANCE CO ADDRESS: ____ ____________________ _________ ___________________

Number / Street / apt # City State Zip

IF NOT THE PATIENT - IS THE INSURED PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

IF NO - PLEASE COMPLETE THE FOLLOWING:

ADDRESS: ____________________________________ ___________ _________________________ _________ __________________

NUMBER / STREET APPT # CITY STATE ZIP

HOME OR CELL # ____

DRIVER'S LIC # ______________________________ BIRTHDATE: ________/_________/__________ SS# __________________________

Signature: ____ **Date:** ______________________________