PATIENT REGISTRATION AND INFORMATION

Date: _____

Patient Name: _____ Referring Dentist: _____

Address: _____

City: _____ State: _____ Zip: _____ How Long: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

Employer: _____ Job Title: _____

How long with current employer: _____ Driver's License No.: _____

Business address: _____ City: _____ ZIP: _____

Social Security Number: _____ Date of Birth: _____

Spouse's Name: _____ Spouses's Daytime phone: _____

Nearest Friend or Relative: _____ Phone: _____

(Not Living with you)

Address: _____ City: _____ ZIP: _____

Has any member of your immediate family been treated by Dr. VanDenBerghe in the past? Yes ◯ No ◯ Who _____

(Full Name)

RESPONSIBLE PARTY INFORMATION

Name of person responsible for this account if not above: _____ Relationship: Spouse, Parent, Other ☐ ☐ ☐

Address: _____ How Long?: _____ Phone: _____

Employer: _____ How Long?: _____ Phone: _____

Driver's License No.: _____ Birthdate: _____

PRIMARY DENTAL INSURANCE INFORMATION

Employee: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other

Social Security No.: _____ Birthdate: _____

Employer: _____

Employer Address: _____ State: _____ ZIP: _____

Insurance Co. Name: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Other Phone: _____

SECONDARY DENTAL INSURANCE INFORMATION (If Any)

Employee: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other

Social Security No.: _____ Birthdate: _____

Employer: _____

Employer Address: _____ State: _____ ZIP: _____

Insurance Co. Name: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Other Phone: _____