Goodall
FAMILY DENTISTRY

Registration

Patient's Name: _____Preferred Name: _____

Mailing Address: _____City:_____Zip:_____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Who can we thank for inviting you to our practice? _____

What is the best way to communicate with you (circle all of interest): text / phone / email

Driver's License: ____-_____
State number

Sex: M F Age: _____ Birth Date: ____/____/_____

SS#:_____

Single Married Widow Separated Divorced

Occupation: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Responsible Party's Information *(if someone other than patient)*

Name of responsible party: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Information- *Please present insurance cards*

Insurance company: _____ Name of insured & relationship to patient: _____

Policy Holder's Information:

Birthday: _____ Social Security #:_____ Employer: _____

Policy Holder's address (if different from patient) _____City: _____State: _____Zip: _____

Policy #_____ Group # _____ Ins. Co. phone #_____ Ins. Co. Payor ID#_____

Ins. Co. Address: _____City:_____State:_____ Zip: _____

Do you have additional dental insurance? Yes No (If yes, Please notify our staff)