AFFD Patient Registration Form

Patient's Information:

First Name ____________________ Last Name ___________________________ MI ___ Date _________

Street Address ____________________________________ Home Phone ________________________________

City, State and Zip __________________________________ Work Phone _________________________________

Email Address ____________________________________ Cell Phone __________________________________

Birth Date ___________________________ Social Security Number _________________________

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

Employer Name and Phone Number ____

Student: Full-Time Part-Time School Name __________________________________

Spouse's Name __________________________________ Spouse's Work Phone ____________________________

Emergency contact _______________________________ Emergency contact's number ______________________

Reason for Visit ____

Do you require pre-medication prior to dental treatment? No Yes _________________________________

How did you learn of our office? ____

Responsible Individual (if other than the patient):

First Name ____________________ Last Name ___________________________ MI ___ Date ______________

Street Address ____________________________________ Home Phone ________________________________

City, State and Zip __________________________________ Work Phone ________________________________

Birth Date _____________________________ Social Security Number _________________________

Relationship to Patient _______________________________

Employer Name ___________________________________

Primary Insurance Information (if applicable):

Name of Policy Holder (if different from Responsible Individual) ____

Policy Holder Birth Date ________________ S.S. N / Subscriber ID #__________________________

Employer Name and Phone Number____

Insurance Company ____ Group # _____________________________

Insurance Company Phone Number_________________________________

Relationship to Patient __________________ Is the patient covered under more than one dental plan? Yes No

Secondary Insurance Information (if patient covered under more than one dental plan):

Name of Secondary Insurance Policy Holder ____

Policy Holder Birth Date ________________ S.S.N./ Subscriber ID # _______________________________

Employer Name and Phone Number____

Insurance Company ____ Group # _____________________________

Insurance Company Phone ____

Relationship to Patient __________________

The above information is accurate and complete to the best of my knowledge.

Signature (patient or responsible individual) _______________________________________ Date ______________