



PATIENT REGISTRATION



Date: _____ Date of Birth: _____

Patient Name: _____ SS# _____

Male _____ Female _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Home Address: Street _____

City _____ State _____ Zip _____

Phone: Home () _____ Business () _____

Employer: _____ Other () _____

If patient is a minor, who is legally responsible? _____

SS# _____

In case of emergency, who should we contact? _____

Phone () _____ Relationship _____

Referred by: _____

Method of Payment: Cash _____ Check _____ Charge Card _____

DENTAL INSURANCE INFORMATION

Name of Insurance Company? _____ Phone () _____

Insurance Address: _____

Subscriber's Name: _____ SS# _____

Date of Birth: _____ Relationship to Patient: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Is patient covered by Secondary Insurance: Yes _____ No _____

Name of Secondary Insurance Company: _____ Phone () _____

Insurance Address: _____

Subscriber's Name: _____ SS# _____

Date of Birth: _____ Relationship to Patient _____

Subscriber's Employer: _____ Group of Policy Number: _____

I hereby authorize payment of the dental and insurance benefits directly to Dothan Endodontic Associates, P.C. and authorize them to release dental information to my insurance company in order for claims to be processed.

Signature of patient or guardian of patient