SOUTHERN FAMILY DENTAL GROUP

PATIENT REGISTRATION

PATIENT LAST NAME: _____**FIRST:** _____**M.I:**_____

Preferred Name: _____ Date of Birth: _____ SS#: _____

Address: _____City:_____State:_____ Zip: _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email: _____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Subscriber Name _____	Subscriber Name _____
Subscriber SS# _____	Subscriber SS# _____
Subscriber ID _____	Subscriber ID _____
Subscriber Address _____	Subscriber Address _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ____Self __Spouse ___Child ___Other	Relationship to Subscriber ____Self __Spouse ___Child ___Other
Employer Name_____	Employer Name_____
Employer Phone _____	Employer Phone _____
Insurance Company_____	Insurance Company_____
Insurance Group # _____	Insurance Group # _____
Insurance Phone _____	Insurance Phone _____

PLEASE PRESENT YOUR INSURANCE CARD TO BE PHOTOCOPIED FOR OUR RECORDS

RESPONSIBLE PARTY *(if minor)*

Last Name: _____ First: _____ ____ Initial____

Address: (if different) _____Date of Birth: _____

City: _____State: _____ Zip: _____ _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

SS#:_____Email_____

Emergency Contact:

Last Name: _____ First: _____ Initial:_____

Telephone (Home) _____ (Work) _____(Mobile) _____