

Sara B. Northcutt

Family and Cosmetic Dentistry

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder
 Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cellular: _____

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

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail _____ I would prefer not to receive correspondences or reminders via e-mail.

Employment Status: Full Part Time Retired

Student Status: Full Part Time

Medicaid ID: _____ Pref. Dentist _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Insurance Group # _____

Prev. Dentist Name: _____

Referred By: _____

Pre-Medication: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured : Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: \$ _____ .00 Rem. Deduct: \$ _____ .00

Secondary insurance Information

Name of Insured: _____ Relationship to Insured : Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____