BEECHWOLD DENTAL CARE Patient Registration

Patient Information

First Name: ________________________ Last Name: __________________________ Middle Initial____

Preferred Name: ___________________________ **Patient is:** [ ] Policy Holder [ ] Responsible Party

Address: ____

City, State, Zip: ____

Home Phone: _______________________

Work Phone: ____________________ Ext: ___________ Cellular: _____________________________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Birth Date: _____________________ Age: _______ Sex: [ ] Male [ ] Female

SSN: _________________________ Drivers License: _________________________

E-Mail: ____

[ ] I would like to receive correspondences via email.

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired Referred By: ____________________

Student Status: [ ] Full Time [ ] Part Time Previous Dentist: _________________

Medicaid ID: ___________________ ER Contact: _____________________________

Preferred Dentist: ___________________ ER Contact #: ____________________________

Employer ID: ___________________ Preferred Pharmacy: _____________________________________

Carrie ID: _____________________ Preferred Hygienist: ______________________________________

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: _________________________ Middle Initial_______

Address: __________________________________ Address 2: __________________________________

City, State, Zip: ____

Home Phone : ______________________

Work Phone: _________________________ Ext: _____________ Mobile: _________________________

Birthdate: _________________ SSN: ____________________ Drivers License: _____________________

[ ] Responsible Party is also Policy Holder for Patient [ ] Primary Insurance Policy Holder [ ] Secondary

Primary Insurance Information

Name of Insured: ________________________ Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured SSN:________________________ Insured Birth Date: ___________________

Employer: ________________________ Ins. Company: ___________________________

Address: _________________________ Address: _______________________________

City, St, Zip: ______________________ City, St, Zip: ____________________________

Secondary Insurance Information

Name of Insured: ________________________ Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured SSN:________________________ Insured Birth Date: ___________________

Employer: ________________________ Ins. Company: ___________________________

Address: _________________________ Address: _______________________________

City, St, Zip: ______________________ City, St, Zip: ____________________________