PATIENT REGISTRATION

(Please print clearly.)

Today's Date:	Primary Care Physician Name and Phone Number:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Preferred Name:	Family status: ☐ Married ☐ Single ☐ Child ☐ Other

Home phone	Work phone	Cell phone	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Best phone number to reach you:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Email address:	May we communicate with you by email? ☐ Yes ☐ No

Whom may we thank for referring you to our practice?

Name and phone number of person to contact in case of emergency:

INSURANCE INFORMATION

Dental Insurance Primary Carrier

Insurance Company:	Group No:	Employer Name:	Insured's Name:

Insured's DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured's ID No:	Insured's SSN

Dental Insurance Secondary Carrier

Insurance Company:	Group No:	Employer Name:	Insured's Name:

Insured's DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured's ID No:	Insured's SSN

Medical Insurance Primary Carrier

Insurance Company:	Group No:	Employer Name:	Insured's Name:

Insured's DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured's ID No:	Insured's SSN

Medical Insurance Secondary Carrier

Insurance Company:	Group No:	Employer Name:	Insured's Name:

Insured's DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured's ID No:	Insured's SSN

CONSENT FOR SERVICES

☐ By checking this box, I consent to the use of photographs taken of me by Dr. Ronald M. Margolies for use in educational publications, materials, and/or programs, marketing, publicity, or advertising, or other reasonable purposes.

☐ I have read and agree to the above conditions

Signature of Patient/Guardian *Date*