COLUMBUS DENTAL CARE, PLLC

Patient Registration Form

PATIENT INFORMATION- (who is receiving treatment today)

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____
Address: _____ Address 2: _____
City/State/Zip: _____, _____, _____
Home #: _____ Cell #: _____ Work #: _____
Date of Birth: _____ SS#: _____
Email: _____ Yes, I would like correspondence via email

RESPONSIBLE PARTY- (who is responsible for account above and beyond insurance, if applicable)

First Name: _____ Middle Initial: _____ Last Name: _____
Preferred Name: _____
Address: _____ Address 2: _____
City/State/Zip: _____, _____, _____
Home #: _____ Cell #: _____ Work #: _____
Date of Birth: _____ SS#: _____
Email: _____ Yes, I would like correspondence via email

Preferred Pharmacy: (Name & Address) _____
Emergency Contact: (Name & Phone #) _____
How were you referred to our office? _____

PRIMARY INSURANCE- (who carries the dental insurance for the patient)

Name of Insured: _____
Address: _____ Address 2: _____
City/State/Zip: _____, _____, _____
Date of Birth of Insured: _____
SS# of Insured: _____ ID# of Insured: _____
Name of Employer of the Insured: _____
Name of Insurance Company: _____Grp#: _____

SECONDARY INSURANCE- (additional coverage through a partner/other source)

Name of Insured: _____
Address: _____ Address 2: _____
City/State/Zip: _____, _____, _____
Date of Birth of Insured: _____
SS# of Insured: _____ ID# of Insured: _____
Name of Employer of the Insured: _____
Name of Insurance Company: _____Grp#: _____