PATIENT REGISTRATION

Patient's name: ___________________________________
First MI Last

How do you wish to be addressed? __________________

If child, parent's name(s): ___________________________

Birthdate: ___/___/___ ☐ male ☐ female

☐ single ☐ married ☐ divorced/separated ☐ widowed ☐ minor

Telephone numbers
Home: _____________________
Office: _____________________
Cell: _____________________

Residence address

Street: ____

City: _____________________ State: ____ Zip: _______

Mailing address (if different from residence)

Street/P.O. Box: ___________________________________

City: _____________________ State: ____ Zip: _______

Patient/parent employed by: ________________________

Present position: __________________________________

Spouse/parent employed by: ________________________

Present position: __________________________________

Person responsible for this account: __________________

Other family members in this practice: ________________

Patient/parent social security number: ________________

Spouse/parent social security number: ________________

Someone (friend or relative not living with you)
to notify in case of emergency:

Name: ______________________ Phone: ___________

I attest to the accuracy of the information provided on this form.

____________________________________ ___/___/___
Patient's/parent's signature Date

DENTAL INSURANCE – FIRST COVERAGE

Employee name ______________________________
SSN _______________________ Birthdate___/___/___
Employer ______________________________
Insurance company ______________________________
Address ______________________________
____
____
Telephone ______________________________
Policy number ______________________________
Union/local number ______________________________

DENTAL INSURANCE – SECOND COVERAGE

Employee name ______________________________
SSN _______________________ Birthdate___/___/___
Employer ______________________________
Insurance company ______________________________
Address ______________________________
____
____
Telephone ______________________________
Policy number ______________________________
Union/local number ______________________________

MEDICAL INSURANCE – FIRST COVERAGE

Employee name ______________________________
SSN _______________________ Birthdate___/___/___
Employer ______________________________
Insurance company ______________________________
Address ______________________________
____
____
Telephone ______________________________
Policy number ______________________________
Union/local number ______________________________

MEDICAL INSURANCE – SECOND COVERAGE

Employee name ______________________________
SSN _______________________ Birthdate___/___/___
Employer ______________________________
Insurance company ______________________________
Address ______________________________
____
____
Telephone ______________________________
Policy number ______________________________
Union/local number ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have received a Privacy Practices Notice from the dental practice of Paul S. Lewis, DDS, MS.

____________________________________ ___/___/___
Patient's/parent's signature Date