STAHL DENTAL STUDIO

Patient Registration

DATE ______________________

1. YOUR INFORMATION

LAST NAME ______ FIRST NAME ______ M.I. ______

NAME YOU PREFER TO BE CALLED BY ______

PREFERRED METHOD OF CONTACT: ☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL

DO WE HAVE YOUR PERMISSION TO TEXT APPOINTMENT CONFIRMATIONS TO YOUR CELL PHONE? ☐ Yes ☐ No

ADDRESS ______

CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL PHONE ______

EMAIL ______ BIRTHDATE ______ AGE ______ SEX ______

2. DENTAL INSURANCE

Primary Carrier

INSURANCE COMPANY ______

GROUP # ______ INSURED'S ID # ______

EMPLOYER NAME ______

INSURED'S NAME ______

INSURED'S DATE OF BIRTH ______

INSURED'S RELATIONSHIP TO PATIENT ______

INSURED'S SSN ______ PATIENT'S SSN ______

Secondary Carrier

INSURANCE COMPANY ______

GROUP # ______ INSURED'S ID # ______

EMPLOYER NAME ______

INSURED'S NAME ______

INSURED'S DATE OF BIRTH ______

INSURED'S RELATIONSHIP TO PATIENT ______

INSURED'S SSN ______ PATIENT'S SSN ______

3. ACCOUNT INFORMATION

NAME OF PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ______

RELATIONSHIP TO PATIENT ______ SSN ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

EMPLOYER'S NAME ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

4. GETTING TO KNOW YOU

Is there a friend or family member who is also a member of our practice?

NAME AND RELATIONSHIP ______

How did you hear about us?

______

______

PERSON TO CONTACT FOR EMERGENCY ______

HOME PHONE ______ CELL PHONE ______

Please turn over...