Bellbrook *Neighborhood Dental*

REGISTRATION

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone _____ Home Phone _____

SS# _____ Birth Date _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T. / P.T., Name of School _____ City _____

Patient's or Parent's/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birth Date _____ SS# _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ **YES** ☐ **NO**

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel # _____ Grp # _____ Policy / ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit? _____

Do you have any Additional Insurance? ☐ **YES** ☐ **NO** **If yes, complete the following:**

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel # _____ Grp # _____ Policy / ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit? _____

X _____

Signature of Patient or Parent / Guardian if Minor

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