BARRY FAMILY DENTISTRY, LLC

PATIENT REGISTRATION

Patient Information:

First Name ____________________ Last Name ____________________ Middle Initial____
Address ____
City, State, Zip____
Home Phone ___________________________ Cell Phone ____________________________
Birth Date ___________________ Age ________ Soc Sec ____________________________
Sex: ☐M ☐F Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Responsible Party (If someone other than patient):

First Name ____________________ Last Name ____________________ Middle Initial____
Address ____
City, State, Zip____
Home Phone ___________________________ Cell Phone ____________________________
Birth Date ___________________ Age ________ Soc Sec ____________________________

Insurance Information:

Insured Name ____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Social Security # ____
Insured Birth Date: ____
Employer ____
Insurance Company ____
Address ____
City, State, Zip ____
Insurance Company Phone # ____

Secondary Insurance Information:

Insured Name ____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Social Security # ____
Insured Birth Date: ____
Employer ____
Insurance Company ____
Address ____
City, State, Zip ____
Insurance Company Phone # ____