MICHAEL SWEENEY, DMD **PATIENT REGISTRATION FORM**

PATIENT REGISTRATION

Today's Date _____

Patient's Name_____Male___Female___ Martial Status S M D W

Address_____

City_____ State_____ Zip_____ DOB_____ Soc Sec ____-____-_____ (Required for Insurance)

Home Phone_____Work Phone_____Cell Phone_____

Spouse's Name_____Work Phone_____Cell Phone_____

Emergency Contact _____Relationship_____Phone_____

Email_____ I would like to receive correspondences via email ____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name if different than patient's_____

Is Responsible Party a patient in our office Yes __ No __ Relationship to patient_____

Responsible Party's Address_____

City_____ State_____ Zip_____ DOB_____ Soc Sec ____-____-_____ (Required for Insurance)

Home phone_____Work phone_____Cell phone_____

Employer_____Address_____

Email_____ I would like to receive correspondences via email ____

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name_____ DOB_____ Soc Sec ____-____-_____

Employer_____ Business Address_____ Employee I.D.#_____

Insurance Company_____ Address_____

Group#_____ Patient's Relationship to Subscriber Self___ Spouse___ Dependent___

Have you used your dental insurance benefits this year? Yes___ No___

Are you covered under more than one dental plan? Yes___ No___ If Yes, Please fill out next section

Subscriber's Name_____ DOB_____ Soc Sec ____-____-_____

Employer_____ Business Address_____ Employee I.D.#_____

Insurance Company_____ Address_____

Group#_____ Patient's Relationship to Subscriber Self___ Spouse___ Dependent___

How did you hear about our office? Website___ Facebook___ Patient's Referral Name_____