PATIENT REGISTRATION AND HISTORY

NAME AND ADDRESS

Last, First: _____ _____
Street Address: _____
City, State, Zip Code: _____
Date Of Birth: _____

Sex: MALE FEMALE

Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED
Spouse's Name: _____
Spouse's Birth Date: _____

EMPLOYMENT OR SCHOOL for patient

Name: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____

PRIMARY DENTAL INSURANCE
Place of employment: _____
Social Security #: _____
Insurance Company: _____
Group #: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____

SECONDARY DENTAL INSURANCE
Place of employment: _____
Social Security #: _____
Insurance Company: _____
Group #: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____

I, the undersigned, hereby authorize payment of the insurance benefits (otherwise payable to me) directly to Marybeth D. Shaffer, D.M.D. and I agree to be and hereby am fully responsible for total payment to Dr. Shaffer for procedures performed in this office, including any amounts which are not covered by any dental insurance I might have.

Signature _____ Date: _____/_____/_____