HEALTHY SMILES OF DELAWARE, PA

Patient Registration

Patient Information:

First Name:__________________________ Last Name:____________________________ M.I.____________________

Address:____

City, State, Zip Code:____

Home Phone:(____)______________________Work:(____)_______________________Ext:______________________

Cell Phone:(____)________________________

Sex:______M ______F Birthdate:_______/_______/______ SSN:______-_____-_______

E-Mail Address:____

Marital Status: Single Married Divorced Widowed

Primary Insurance Information:

Policy Holder's Name:____

Self___________ Spouse___________ Parent___________ Other (Explain)_________________________________

SSN:_____________________________________ Birthdate:____

Employer:____

Employer's Address:____

City, State, Zip:____

Dental Insurance Co:_________________________________Plan Number/ Type:______________________________

Member ID Number:____Group Number:__________________________

Mailing Address: ____

City, State, Zip:____

Secondary Insurance Information:

Policy Holder's Name:_________________________________ SSN:______-_____-_____ Birthdate:____/_____/__

Dental Insurance Co:_________________________________Plan Number/ Type:______________________________

Member ID Number:____Group Number:__________________________

Mailing Address: ____

City, State, Zip:____

2019