David P. Young, D.M. D., DICOI

PATIENT REGISTRATION

Patients First Name: _____ Last Name: _____ Middle Initial_____

Preferred Name:_____

Patient Is: _____ Policy Holder

_____ Responsible Party

RESPONSIBLE PARTY (if someone other than the patient)_____

First Name:_____Last Name: _____Middle Initial:_____

Address:_____Address 2: _____

City, State, Zip: _____Page:_____

Home Phone: _____Work Phone: _____Ext: _____Cellular_____

Birth Date_____Soc Sec: _____ Drivers Lic:_____

_____ Responsible Party is also a Policy Holder for Patient _____Primary Insurance Policy Holder _____Secondary Insurance Policy Holder

PATIENT INFORMATION

Address:_____Address 2: _____

City:_____State:_____Zip: _____Pager:_____

Home Phone:_____Work Phone: _____Ext: _____Cellular: _____

Sex: _____Male _____Female Marital Status:_____ Married _____ Single Divorced _____ Separated _____ Widowed

Birth Date: _____Age:_____Soc. Sec:_____Drivers Lic:_____

E-mail: _____ _____I would like to receive correspondences via e-mail.

SECTION 2

Employment Status: _____ Full Time _____Part Time _____ Retired

Student Status: _____ Full Time _____Part Time

Medicaid ID: _____ Pref. Dentist:_____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

SECTION 3

Family Member Ph #: _____

Transportation #: _____

Care Credit #:_____

Credit Card #:_____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ____ Self ____Spouse ___ Child ___ Other

Insured Soc. Sec: _____ Insured Birth Date:_____

Employer: _____ Ins. Company _____

Address: _____ Address _____

Address 2: _____ Address 2 _____

City,State.Zip:_____ City,State,Zip _____

Rem. Benefits: _$_____ Rem Deduct: _$_____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____Relationship to Insured: ____ Self ____ Spouse __ Child ____Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company _____

Address: _____ Address_____

Address 2: _____ Address 2 _____

City.State.Zip: _____ City,State,Zip _____

Rem. Benefits: _____$_____ Rem. Deduct: _____$_____