María Saunders, DMD
General, Implant & Cosmetic Dentistry

INNOVATION DENTAL

PATIENT REGISTRATION

ID: Chart ID:

First Name:_____ Last Name:_____ Middle Initial: _____

Preferred Name:_____

Patient is: □ Responsible Party □ Policy Holder

RESPONSIBLE PARTY: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial: _____

Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

PATIENT INFORMATION:

Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____ Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

PATIENT INFORMATION (SECTION 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Preferred Dentist:_____ Preferred Hygienist:_____ Preferred Pharmacy:_____

Referred By : _____

Medicaid ID: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

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