DENTAL GROUP ASSOCIATES OF FLORIDA, PA

PATIENT REGISTRATION

Today's Date: 04/13/2020

(Title): Dr. Mr. Mrs. Ms. Miss.

First: ____________ Middle: ________ Last: ________________ Jr. Sr.

Street: ________________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: (____________ Cell Phone: ____________

Email Address: ________________________________

May we contact you by email? **YES** No May we contact you by text? **YES** No

Sex: **M** **F** X Date of Birth: ____________ Social Security #: ____________

Marital Status: **S** X **M** **D** **W** Spouse's Name: ________________

Emergency Contact Name: ________________ Relationship: ____________

Emergency Contact Number: ________________

Physician's Name: ________________ Physician's Phone: ____________

Whom may we thank for referring you? ____________ How did you hear about us (check all that apply)?

❑ Mailer ❑ Google ❑ Friends/Family ❑ Insurance ❑ Internet ❑ Yellow Pages ❑ Other ____________

INSURANCE INFORMATION: Do you have Dental Insurance? **Yes** No

PRIMARY INSURANCE			
Subscriber Name:		Employer Name:	
Subscriber SSN:		Employer Phone:	
Date of Birth:		Insurance Company:	
Relation to the	❑ Self ❑ Spouse	Insurance Group #:	
Subscriber:	❑ Child ❑ Others	Insurance Phone #:	
Please present your Insurance Card and Driver's License to the receptionist to be photocopied*			

SECONDARY INSURANCE			
Subscriber Name:		Employer Name:	
Subscriber SSN:		Employer Phone:	
Date of Birth:		Insurance Company:	
Relation to the	❑ Self ❑ Spouse	Insurance Group #:	
Subscriber:	❑ Child ❑ Others	Insurance Phone #:	
Please present your Insurance Card and Driver's License to the receptionist to be photocopied*			

I, hereby by virtue of my signature below, give my consent to allow this office and staff to leave messages and speak to person(s) listed regarding scheduling, treatment, and financials, or other information as necessary.

Name: ________________________ **Relationship** ____________

Name: ________________________ **Relationship** ____________

Name: ________________________ **Relationship** ____________

If the patient is under the care of a facility and it is listed, consent will apply for all staff of the facility.

______ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

I, hereby by virtue of my signature below attest that all information provided on this Patient Registration Form is correct.

Signature of Patient, Parent or Guardian:	**Date:** 04/13/2020