HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY

# PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

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: Pager:

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: Trevor Scheff, DDS

Employer ID: Pref. Pharmacy:

Section 3

Referral Source::

Previous Dentist::

Emergency Contact::

Emergency Contact #::

Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer:

Address:

Address 2:

City,State,Zip:

Ins. Company:

Address:

Address 2:

City,State,Zip:

Secondary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer:

Address:

Address 2:

City,State,Zip:

Ins. Company:

Address:

Address 2:

City,State,Zip: