Ferrell Family Dentistry

Date: _____

PATIENT REGISTRATION

First Name: _____ Last Name: _____ MI: _____ Preferred Name_____

Address: _____ City: _____ State: _____ Zip Code: _____

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

Birth Date: _____ SS#: _____ Email address: _____

Sex: Male ◯ Female ◯ Marital Status: Married ◯ Single ◯ N/A ◯

Emergency Contact: _____ Emergency Contact #: _____

Previous Dentist: _____ Phone Number: _____

How did you hear about us? (Please circle one.) Postcard/Flyer FFD Website Insurance Website Drive by/sign

Friend/Relative/Other: Name_____

I give permission to be contacted via cell phone for all dental related matters, including account information:

Please check one _____yes _____ no

Responsible Party:

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

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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

Birth Date: _____ SS#_____ Email address: _____

Sex: Male ◯ Female ◯ Marital Status: Married ◯ Single ◯ N/A ◯

Insurance Information: ***(* Patient/Responsible Party is responsible for all charges not covered by insurance.)***

Policy Holder's Name: _____ Relationship to Patient: Self ◯ Spouse ◯ Child ◯ Other ◯

Policy Holder's Employer: _____ Phone Number: _____

Insurance Company: _____ _____Policy Holder's SS#: _____

Claim Address: _____Policy Holder's Birth date: _____

Address 2: _____Policy Holder's Group #: _____

City, State, Zip: _____ Policy Holder's ID #: _____

Patient/Responsible Party Signature_____