Abundant DENTAL CARE

Today's Date:

PATIENT REGISTRATION

Confidential Personal Information

Name ☐ M ☐ F Sex / / DOB Age

Street Address City State/Zip

☐ Single ☐ Married ☐ Separated ☐ Widowed Marital Status - - Social Security Number

( ) - Cell Phone ( ) - Home Phone Email

Employer ( ) - Work Phone ☐ Yes ☐ No Are you a full-time student?

/ / Mother's DOB (if patient is a minor) / / Father's DOB (if patient is a minor) Name of Spouse (or parent if patient is a minor)

( ) - Spouse's Cell Phone ( ) - Spouse's Work Phone Spouse's Email Spouse's Employer

Responsible Party

☐ Self ☐ Other Person responsible for account Name (if other than self) Relationship (if other than self) Driver's License Number

( ) - Cell Phone ( ) - Work Phone Email

Emergency Contact

Emergency Contact Name ( ) - Cell Phone Email

Other

How were you first introduced to Abundant Dental Care? ☐ Mailer ☐ Web Search ☐ Social Media ☐ Drove By

☐ Referral from family/friend ☐ Insurance Carrier ☐ Other _____

Dental Insurance

	Primary Insurance	Secondary Insurance
Insured's Name & DOB:		Insured's Name & DOB:
Social Security #:		Social Security #:
Insurance Carrier:		Insurance Carrier:
Insurance Carrier's Phone#:		Insurance Carrier's Phone#:
Insured's Employer:		Insured's Employer:
Group #: ID#:		Group #: ID#:

Check all that apply: ☐ I do not have dental insurance ☐ I am interested in receiving information on an In-House Discount Plan