

PREHN DENTAL OFFICE

FREDERICK C. PREHN, D.D.S.

PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

PATIENT'S NAME _____ NICKNAME _____ MIDDLE INITIAL _____

SEX: M F BIRTHDATE: _____

SINGLE ___ MARRIED ___ SEPARATED ___ WIDOWED ___ DIVORCED ___

NAME OF SPOUSE: _____

IF PATIENT IS A MINOR, PARENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ E-MAIL _____

PATIENT'S SOCIAL SECURITY # _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

WHO MAY WE THANK FOR THIS REFERRAL? _____

BILLING INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

BILLING NAME _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER NAME _____ BUSINESS PHONE _____

SPOUSE'S EMPLOYER NAME _____ BUSINESS PHONE _____

DENTAL INSURANCE INFORMATION (PRIMARY)

INSURED NAME _____ RELATION _____ BIRTHDATE _____

EMPLOYER PROVIDING COVERAGE _____ GROUP # _____

INSURANCE COMPANY NAME _____ SS# _____

DENTAL INSURANCE INFORMATION (SECONDARY)

INSURED NAME _____ RELATION _____ BIRTHDATE _____

EMPLOYER PROVIDING COVERAGE _____ GROUP # _____

INSURANCE COMPANY NAME _____ SS# _____

MEDICAL INSURANCE INFORMATION

EMPLOYER PROVIDING COVERAGE _____ GROUP # _____

INSURANCE COMPANY NAME _____ SS# _____

(PLEASE READ AND SIGN THE BACK OF THIS FORM)