BARBAG DENTAL
CREATING BEAUTIFUL SMILES

PATIENT REGISTRATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name_____Date_____
Last First MI (Preferred)

Address_____

City_____ State_____ Zip_____

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone_____ Wireless Phone_____ Work Phone_____

Email Address_____

Preferred contact method [ ] Home Phone [ ] Work Phone [ ] Wireless Phone [ ] Email

How did you hear about us? (If someone referred you here, please write down their name so we can thank them.)

_____

OTHER INFORMATION

Occupation_____ Employer_____

Work Address _____

In case of emergency, who should be notified? _____Number_____

Who is responsible for this account? _____

Relationship to patient _____

INSURANCE POLICY

Subscriber ID # _____

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber SS # _____Subscriber DOB _____

Insurance Company _____Phone_____

Employer_____ Group Name _____Group #_____

Please present insurance card to receptionist.

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