PATIENT REGISTRATION

GREENCASTLE 20/20 DENTAL
819 E FRANKLIN ST.
GREENCASTLE, IN 46135

Patient's Name **Birth date** **Age** **Sex: M F**

Home Address	**City**	**State**	**Zip**

Home Phone # **Work Phone #** **YOUR cell phone #**	***Please Circle One:*** Single, Married, Separated, Widow	**Your Soc Sec. #** **(is not necessary if paying at the time of service)**
Your Employer **Occupation**		

Are you a full time student? ☐Yes ☐ No

If patient is minor we need: *Mother's Name & Birth date* *Father's Name & Birth date*

Person paying this bill **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

Reason for your visit today ?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Policy #	Group # Local #

Patient Signature (or Parent of Child) ____________________ **Date** __________________________