Epic Dental Associates

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REGISTRATION FORM

Section I: **Patient Information** **Date________________**

Name: ____ I prefer to be called: ____________________
Address: _________________________________City: ____________________State: _______Zip____________
Phone (_____) _____________ Work Phone (____) ____________ Cell Phone (_____) _______________
Patient Employer _____________________________
Date of Birth: ____________ Social Security Number: ____________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_______________________ City/State______________________ ☐ FT ☐ PT
Spouse or Parent's Name:_______________________ Employer______________ Work Phone_________
Whom may we thank for referring you? ____
Person to contact in case of emergency____________________________ Phone____________________
Email Address____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: ____ Date of Birth: __________________________
Address: ____
City: _________________________ State:________ Zip:__________ Phone: (___)________________
Employer____________________ Work Phone (___) _____________ SSN#_______________________

Do you have Dental Insurance? ☐ Yes ☐ No

Section II **Insurance Information**

Name of Insured___________________________DOB____________Relationship to Patient _____________
SSN#:___________________ Name of Employer:__________________ Work Phone: (___)________________
Address of Employer:____________________________City______________State:_______Zip _____________
Insurance Company_______________________ Group #_________________ ID#____________________
Ins Co Address:______________________________________ Ins Co. Phone:_______________________

------------ DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured___________________________DOB____________Relationship to Patient _____________
SSN#:___________________ Name of Employer:__________________ Work Phone: (___)_____________
Address of Employer: ____________________________City: _______________State: _______Zip _________
Insurance Company_______________________ Group #_________________ ID#____________________
Ins Co Address:______________________________________ Ins Co. Phone:_______________________