KEVIN Gagliardi DMD AND ASSOCIATES

Patient Registration

ID: _____ Chart ID: _____ Patient is: ☐ Policy Holder ☐ Responsible Party

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Pager: _____

Birth Date: _____ Soc. Sec.: _____ Driver's License: _____

☐ Responsible party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Policy Holder

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec.: _____ Driver's License: _____

E-mail: _____ ☐ Iwould like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Preferred Dentist: _____

Employer ID: _____ Preferred Pharmacy: _____

Carrier ID: _____ Preferred Hygenist: _____

Section 3

Referred by: _____

Previous Dntist: _____

Emergency Contact: _____

Emergency Contact #: _____

Receives Txt Msgs.: _____

Primary Insurance Information

Name of Insured: _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2:_ _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct : _____

Secondary Insurance Information

Name of Insured: _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2:_ _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct : _____