PRYOR FAMILY DENTAL

PATIENT REGISTRATION

PATIENT INFORMATION:

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

Preferred Name: _____ Email Address For Appt Notification _____

Address: _____ City/State/Zip Code: _____

Home Phone #: _____ Cellular #: _____ Work #: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Sex: M____ F____ Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Emergency Contact: _____ Emergency Contact #: _____

EMPLOYMENT INFORMATION:

Employment Status: Full Time: _____Part Time: _____ Retired: _____ Student: _____ Unemployed: _____

Name of Employer: _____ Employer Phone #: _____

DENTAL INSURANCE INFORMATION **Please provide card at sign in**

Name of Policy Holder: _____ Relationship to Patient: _____

Insurance Company: _____ Telephone #: _____Group #: _____

Policy Holder's Social Security #: _____ Policy Holder's DOB: _____

RESPONSIBLE PARTY: IF SOMEONE OTHER THAN PATIENT

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip Code: _____

Employer: _____ Phone #: _____

DO YOU REQUIRE PRE-MED BEFORE DENTAL PROCEDURES? YES_____ NO_____

ARE YOU CURRENTLY <u>OR</u> HAVE YOU EVER TAKEN ANY BISPHOSPHONATES (BONE DENSITY MEDICATIONS)?

YES _____ NO _____

ARE YOU CURRENTLY TAKING ANY BLOOD THINNING MEDICATIONS LIKE PLAVIX OR COUMADIN?

YES _____ NO _____

Signature of Patient, Parent or Guardian

_____ Date _____