Shady Cove Family Dentistry

Patient Registration

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

Preferred Name: _____ Birthdate: _____/_____/_____DL#: _____

Responsible Party: ☐Self ☐ Other: _____

Address:_____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Soc. Sec: _____

Home Phone: _____ Cell Phone: _____ ☐ I would like to receive correspondence via text

Work Phone: _____ Employer: _____

E-mail: _____ ☐ I would like to receive correspondence via e-mail

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Referred By: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Number: _____

Insurance Information

Primary Insurance

Subscribers Name: _____ ID #:_____

Subscribers Birth Date: _____/_____/_____ Subscriber Soc. Sec: _____

Relation to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employer: _____ Ins. Company: _____

Secondary Insurance

Subscribers Name: _____ ID #:_____

Subscribers Birth Date: _____/_____/_____ Subscribers Soc. Sec: _____

Relation to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employer: _____ Ins. Company: _____