Beaufort Family Dentistry

Patient Registration

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Male or Female?

Mailing Address:

_____

City_____ State _____

Zip_____ Home Phone: _____

Cell Phone: _____

EMAIL ADDRESS: _____@_____

Responsible Party (ONLY COMPLETE IF SOMEONE OTHER THAN PATIENT)

First Name: _____ Last Name_____

Date of Birth: _____ SSN: _____

Mailing Address:_____

Home Phone: _____ Cell Phone: _____

Insurance Information:

Name of Insured: _____

Relationship to Insured: _____

Insured SSN: _____ Insured Date of Birth: _____

Insurance Name:_____ Insurance Ph #: _____

Employer: _____

Please let our Patient Coordinator know if you have secondary coverage

Emergency Contact:

Name: _____ Phone: _____