Timothy A.  Ungarean DMD, FAGD

Patient Registration

Patient Information:

First Name:_____ Middle Initial:_____Last Name:_____

Address:_____ DOB:_____ Age:_____

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

SS#: _____ Drivers License:_____ Male_____ Female_____

I would like to receive correspondences via email/text: Yes:_____No:_____ Email:_____

Marital Status: Married:_____ Single:____ Divorced:____ Widowed:_____

Responsible Party (if different from patient):

First Name:_____ Last Name:_____ DOB:_____

Address:_____

Home Phone:_____ Work:_____ Cell:_____

SS#: _____ Drivers License:_____ Male_____ Female____

Primary Insurance Information:

Name of Employer:_____ Name of Policy Holder:_____

Policy Holder SS#:_____ Insurance Company:_____

Insurance Member ID #:_____ Relationship to Patient:_____

Secondary Insurance Information:

Name of Employer:_____ Name of Policy Holder:_____

Policy Holder SS#:_____ Insurance Company:_____

Insurance Member ID #:_____ Relationship to Patient:_____

**********PLEASE PROVIDE A COPY OF YOUR DENTAL/MEDICAL CARD TO THE RECEPTIONIST**********