KENDRA S. SCHAEFER, DMD, LLC

PROSTHODONTICSOFMADISON

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PATIENT REGISTRATION

Patient's Name ______________________ Date of Birth ______________________

Street Address ______________________ ☐ Phone ______________ ☐ Cell ______________

City ______________________ State ______________ Zip Code ______________

Patient's Social Security No. ______________________ Email Address ______________________

Patient's Employer ______________________ ☐ Business Phone ______________________

Employer's Address ______________________

Person Responsible for Account ______________________

Relationship to Patient: ☐ Spouse ☐ Parent Guardian ☐ Other: ______________________

Address of Responsible Party ______________________

City ______________________ State ______________ Zip Code ______________

Social Security No ______________________

Responsible Party's Employer ______________________

Employer's Address ______________________

☐ Home Phone ______________ ☐ Cell Phone ______________ ☐ Employment Phone ______________

Who Referred You to Our Office? ______________________ ☐ Dr. ☐ Friend ☐ Internet ☐ Website

Name of General Dentist ______________________

Name of Physician: ______________________ Location: ______________________

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance Co. ______________________

Street Address ______________________

City ______________________ State ______________ Zip Code ______________

Name of Insured Person ______________________ Date of Birth ______________________

Member Number ______________________ Social Security Number: ______________________

Group Number ______________________

Name & Address of Employer ______________________

Name of Secondary Dental Insurance Co. ______________________

Street Address ______________________

City ______________________ State ______________ Zip Code ______________

Name of Insured Person ______________________ Date of Birth ______________________

Member Number ______________________ Social Security Number ______________________

Group Number ______________________

Name & Address of Employer ______________________