KENDRA S. SCHAEFER, DMD, LLC
PROSTHODONTICSOFMADISON
612 RIVER PLACE MONONA, WI 53716
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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 ______________________