Patrick M. Michel, DMD, PA

PATIENT REGISTRATION

Date:_____

Patient Name:_____Preferred Name:_____
First MI Last

Patient Address:_____Birth Date:_____

City, State, Zip: _____

Social Security #:_____Driver's License #:_____

Home Phone:_____ Work Phone: _____Cell Phone:_____

Sex: O-Male O-Female

Marital Status: O-Married O-Single O-Divorced O-Separated O-Widowed

Email Address:_____

O-I would like to receive correspondence via email

Place of Employment:_____

Address of Employer:_____

Employment Status: O-Full Time O-Part Time O-Retired

Student Status: O-Full Time O-Part Time O-Not a Student

Preferred Appointment Times: O-Morning O-Afternoon O-Anytime

O-Monday O-Tuesday O-Wednesday O-Thursday

How did you hear about our office?_____

Responsible Party (if someone other than patient):

Name (First, MI, Last):_____Birth Date:_____

Address:_____Social Security #:_____

City, State, Zip:_____ Driver's License #:_____

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

Primary Insurance Information:

Name of Insured:_____ SS#:_____Birth Date:_____

Relationship to Patient: O-Self O-Spouse O-Child O-Other

Employer:_____ Insurance Company:_____

Emp Address:_____ Ins Address:_____

Emp City, State, Zip:_____ Ins City, State, Zip:_____

Secondary Insurance Information:

Name of Insured:_____ SS#:_____Birth Date:_____

Relationship to Patient: O-Self O-Spouse O-Child O-Other

Employer:_____ Insurance Company:_____

Emp Address:_____ Ins Address:_____

Emp City, State, Zip:_____ Ins City, State, Zip:_____