OHIO FAMILY DENTISTRY

Ohio Family Dentistry
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Patient Registration

Patient Information

Last Name:		First Name:		Initial:
Preferred Name:				
Birth Date:		Soc. Sec. #		Drivers Lic:
Address:				
City:			State:	Zip:
Home Ph:		Cell Ph:		Work Ph: ext
Email:				
☐	No Emails Please			
☐	No Text Messages Please			

How did you hear about us? ____

Responsible Party (if someone other than patient)

Last Name:	First Name:	Initial:
Birth Date:	Soc. Sec. #	Driver License:
Address:		
City:	State:	Zip:
Home Ph:	Cell Ph:	Work Ph: ext
Email:		
Spouse, Parent or Guardian Name:		
Relationship to patient:		

Sex:	☐Male	☐Female	Marital Status:	☐Married	☐Single	☐Divorced	☐Separated	☐Widowed

Primary Insurance Information

Name of Policy Holder:			
Relationship to Insured:	☐Self	☐Spouse	☐Child ☐Other
Policy Holder SSC.# or ID#:		Policy Holder Birth Date:	
Employer:		Group#:	
Insurance Company:		Insurance Co. Ph#:	

Name of other dependent covered under this plan ____

Additional Insurance Information

Is patient covered by additional insurance? ☐ YES ☐ NO

Subscriber Name________________________________Birthdate___________Relation to patient___________________

Address (if different from patient's)______________________________________Phone (___) ______________________

City___________________________________ State_____________ Zip _______________

Subscriber Employed by ____Business Phone (___)__________________

Insurance Company____Social Security # ______________________

Contact #________________________ Group # ________________________Subscriber # _________________________

Name of other dependent covered under this plan ____