ALLYSON A. ABBOTT, DMD ● CHRISTIAN J. LEHR, DMD ● TINA CHOU, DMD ● IVAN MILORADOVIC, DMD

●●●●●●●●● PATIENT REGISTRATION/UPDATE FORM ●●●●●●●●●

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____STATE_____ ZIP_____

HOME PHONE_____

WORK PHONE_____

CELL PHONE_____

BIRTH DATE_____

EMAIL_____

SPOUSE'S NAME_____

BIRTHDATE_____

CELL PHONE_____

WORK PHONE

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME_____

DOB_____SOC.SEC.#_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE #_____

SIGNATURE/DATE_____

PRIMARY DENTAL INSURANCE INFO

INSURANCE CO._____

POLICY HOLDER NAME_____

SOC. SEC. #_____ DOB_____

EMPLOYER_____

GROUP #_____

POLICY/ENROLLEE ID#_____

INS CO ADDRESS_____

_____

INS CO PHONE #_____

SECONDARY DENTAL INSURANCE INFO

INSURANCE CO._____

POLICY HOLDER NAME_____

SOC. SEC. #_____ DOB_____

EMPLOYER_____

GROUP #_____

POLICY/ENROLLEE ID#_____

INS CO ADDRESS_____

_____

INS CO PHONE #_____

EMERGENCY CONTACT (NAME, RELATIONSHIP, PHONE NUMBER)_____

_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

WHO IS YOUR GENERAL DENTIST?_____

I hereby authorize Allyson A. Abbott, DMD, Christian J. Lehr, DMD, Tina Chou, DMD to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I agree to accept full financial responsibility for services rendered including those services not covered by my dental insurance carrier or services that are only partially covered.

_____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR) **DATE**