DR. NARANG
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION

ID _____ CHART ID _____

First Name _____ Last Name _____ Middle initial _____

Patient is: ◯ Policy holder Preferred Name _____

◯ Responsible Party

Responsible Party (If someone other than the patient)

First Name _____ Last Name _____ Middle initial _____

Address _____ Address 2 _____

City, State, Zip _____ Cell: _____

Home Phone _____ Work Phone _____ Ext. _____

Birth Date _____ Soc. Sec. _____ Drivers Lic _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Holder ◯ Secondary Insurance Holder

PATIENT INFORMATION

Address _____ Address 2 _____

City, State, Zip _____ Cell: _____

Home Phone _____ Work Phone _____ Ext. _____

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

Birth Date _____ Soc. Sec. _____ Drivers Lic _____

Email _____ ◯ I would like to receive correspondences via e-mail.

SECTION 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medical ID _____ Pref Dentist _____

Employer ID _____ Pref Pharmacy _____

Carrier ID _____ Pref Hyg _____

SECTION 3

Additional Comments:

PRIMARY INSURANCE INFORMATION

Name of insured _____

Insured Soc. Sec _____

Employer _____

Address _____

Address 2 _____

City, State, Zip _____

Rem Benefits _____ .00

Relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Birth Date _____

Ins. Company _____

Address _____

Address 2 _____

City, State, Zip _____

Rem Deduct _____ .00

SECONDARY INSURANCE INFORMATION

Name of insured _____

Insured Soc. Sec _____

Employer _____

Address _____

Address 2 _____

City, State, Zip _____

Rem Benefits _____ .00

Relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Birth Date _____

Ins. Company _____

Address _____

Address 2 _____

City, State, Zip _____

Rem Benefits _____ .00