ROCKY RIDGE DENTAL ASSOCIATES, LLC

PATIENT REGISTRATION INFORMATION

Welcome to our office. We will do our best to make your appointments as convenient and as pleasant as possible. If at any time you have questions regarding your treatment, your appointments, or our fees, please feel free to ask.

Please tell us whom we may thank for referring you to our office _____

----------**PLEASE PRINT** ----------

Patient's Name _____
First *MI* *Last* *Prefer*

Home Address _____
Number *Street* *Apt. No.*

_____
City *State* *Zip* *Home Telephone*

E-Mail Address: _____

Date of Birth_____ Social Security No. _____ Married _____Single: _____

Employed by _____ Business Telephone _____

Person Responsible for Account - Name_____Date of Birth_____
(If different from patient)

Address _____
Number *Street* *City* *Zip*

Relationship to Patient _____ Home Telephone _____ Bus. Telephone_____

*** IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING ***

PRIMARY INSURANCE COVERAGE

Carrier Name: (Ins. Co.) _____Telephone No. _____

Address: _____

City: _____ State: _____ Zip: _____

Group Plan: (Company Name) _____ Group No: _____

Policy Holders Name: _____ SS#: _____ Date of Birth: _____

SECONDARY INSURANCE COVERAGE

Carrier Name: (Ins. Co.) _____ Telephone No. _____

Address: _____

City: _____ State: _____ Zip: _____

Group Plan: (Company Name) _____ Group No: _____

Policy Holders Name: _____ SS#: _____ Date of Birth: _____

****** PLEASE COMPLETE THE REVERSE SIDE ******