

# Southern Arizona Periodontics, P.L.C.

Periodontics and Dental Implants

## PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_

EXAMINING DENTIST  EDWARD R. COLE, D.D.S.

SUSAN B. SHARP, D.D.S

MR.  MRS.  DR.  MS. PATIENT NAME

NICKNAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

PATIENT'S SS# \_\_\_\_\_

GENDER

MALE

FEMALE

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE? \_\_\_\_\_

WHO REFERRED YOU TO US? \_\_\_\_\_

PERSON TO CONTACT FOR EMERGENCY \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

CLOSEST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

WHO IS YOUR GENERAL DENTIST? \_\_\_\_\_

### PRIMARY DENTAL INSURANCE

### SECONDARY DENTAL INSURANCE

EMPLOYER \_\_\_\_\_

EMPLOYER \_\_\_\_\_

INSURANCE COMPANY NAME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

POLICY HOLDER'S ID (SSN or ID#) \_\_\_\_\_

POLICY HOLDER'S ID (SSN or ID#) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

OCCUPATION \_\_\_\_\_

RELATIONSHIP TO POLICY HOLDER \_\_\_\_\_

RELATIONSHIP TO POLICY HOLDER \_\_\_\_\_

ARE YOU A FULL TIME STUDENT? \_\_\_\_\_

WHERE \_\_\_\_\_

ARE YOU A FULL TIME STUDENT? \_\_\_\_\_

WHERE \_\_\_\_\_

This form **MUST** be completed prior to your first appointment.