PATIENT REGISTRATION

drpieyeah.com
John A. Pagliei, Jr., D.M.D.
PREVENTION, GENERAL & COSMETIC DENTISTRY FOR THE ENTIRE FAMILY

ID ____________________

Chart ID ____________________

First Name ____________________ Last Name ____________________

Patient is: ❍ Policy Holder ❍ Responsible Party

RESPONSIBLE PARTY *(if other than the patient)*

First Name ____________________ Last Name ____________________

Address ____________________

City/State/Zip ____________________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Birth Date ____________________ Social Security # ____________________ Driver's License # ____________________

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

---

PATIENT INFORMATION

Section 1

Address ____________________

City/State/Zip ____________________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________ Pager ____________________

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

Birth Date ____________________ Social Security # ____________________ Driver's License # ____________________

E-mail ____________________ ❍ I would like to receive correspondence via e-mail.

Section 2

Employment Status: ❍ Full-Time ❍ Part-time ❍ Retired ❍ Unemployed Student Status: ❍ Full-Time ❍ Part-time

Medicaid ID ____________________ Pref. Dentist ____________________

Carrier ID ____________________ Pref. Pharmacy ____________________

Employer ID ____________________ Pref. Hygienist ____________________

PRIMARY INSURANCE INFORMATION

Name of Insured ____________________ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security # ____________________ Insured Birth Date ____________________

Employer ____________________ Insurance Company ____________________

Address ____________________ Address ____________________

____________________ ____________________

City/State/Zip ____________________ City/State/Zip ____________________

Rem. Benefits ____________________ Rem. Deduct ____________________

SECONDARY INSURANCE INFORMATION

Name of Insured ____________________ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security # ____________________ Insured Birth Date ____________________

Employer ____________________ Insurance Company ____________________

Address ____________________ Address ____________________

____________________ ____________________

City/State/Zip ____________________ City/State/Zip ____________________

Rem. Benefits ____________________ Rem. Deduct ____________________