

# WELCOME to PROSPER DENTISTRY & ORTHODONTICS, PA

## Patient Registration

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_ Driver's Lic# & State: \_\_\_\_\_

Patient's Spouse's Name: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Physical Address: \_\_\_\_\_  
Street City State Zip

Home Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work #: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_  
Street City State Zip

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## Person Responsible for Payment (If other than the patient. If minor, please list the parent's/guardian's name(s).)

Name: \_\_\_\_\_ Driver's Lic# & State: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Physical Address: \_\_\_\_\_  
Street City State Zip

Home Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work #: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_  
Street City State Zip

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## Emergency Contact (Local friend or relative not living with you.)

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
Street City State Zip

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**If you have dental insurance, please fill out the following information. As a courtesy to our patients, we will file most primary dental insurance coverage. However, if a patient carries a secondary dental coverage it will be the sole responsibility of the patient to file for those benefits due to length of time involved in payment of claims process.**

## Primary Dental Insurance (need a copy of the insurance card)

Name of Insured (the employee): \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured's Ind. Policy ID# : \_\_\_\_\_

Insured's Social Security # : \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_ Insurance Phone#: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_  
Street City State Zip

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Whom may we thank for referring you? \_\_\_\_\_ or How did you hear about us? \_\_\_\_\_

