

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

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

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

Name: _____ Phone#: _____

Physical Address: _____
Street City State Zip

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

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