Michael R. Thomas D.D.S., P.L.L.C.

PATIENT REGISTRATION

ABOUT YOU

First Name:_____ **Preferred Name**_____ **Last Name:**_____ **Middle Initial:**____

☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security#: _____–_____–_____

Address:_____ City/State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Email:_____

Name of Spouse: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Are you a full time student?: ☐ Y ☐ N If Yes, where: _____

Employer: _____ Employer Address: _____ Employer Phone: _____

Who may we thank for Referring you: _____ ☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Employer ☐ Other_____

Who is your Preferred Dentist: _____ Preferred Hygienist: _____ Pharmacy: _____

EMERGENCY INFORMATION

Person to contact in case of emergency: _____ Phone: _____ Relationship: _____

PERMISSION TO SHARE INFORMATION (FOR PATIENTS 18 years of age and older)

☐ I give my permission for Michael R. Thomas D.D.S., P.L.L.C. to share my medical/dental and account information with the following persons _____
Initial

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

ACCOUNT INFORMATION

Who is responsible for this account ☐ Self ☐ Parent ☐ Spouse ☐ other ☐ **I DO NOT HAVE DENTAL INSURANCE**

Person responsible for this account if not self: _____ Address:_____ Phone: _____

Date of Birth: _____/_____/_____ City/State: _____ Zip: _____

PRIMARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____–_____–_____

Policy Holder Address:_____ City/State: _____ Zip: _____

Policy Holder Home Phone:_____ Cell Phone:_____

Policy Holder Employer:_____ Address:_____Phone: _____

Insurance Company Name: _____ Address:_____

City/State :_____ Zip: _____

Group Number: _____ Policy Holder ID#: _____

SECONDARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____–_____–_____

Policy Holder Address:_____ City/State: _____ Zip: _____

Policy Holder Home Phone:_____ Cell Phone:_____

Policy Holder Employer:_____ Address:_____ Phone: _____

Insurance Company Name: _____ Address:_____

City/State :_____ Zip: _____

Group Number: _____ Policy Holder ID#: _____

PATIENTS UNDER 18 years of age (MINORS)

Name of person completing the patient registration: _____

Relationship to patient: ☐ Parent ☐ Grandparent ☐ Other_____

Name of person accompanying you to todays appointment _____

Relationship to patient: ☐ Parent ☐ Grandparent ☐ Other_____