Belleville Dental Care

Patient Registration Date: __________

Patient Information:

Name________________________________Birthdate___________SS#_____________

Address_________________City______________State_______________zip_____________

Email____________________ Home phone_____________ Cell phone______________

Check Appropriate Box: ( ) Minor ( ) Single ( ) Married ( ) Other

Responsible Party:

Person responsible for account_______________________ Relationship____________________

Address______________________City_________________State______________Zip___________

Email________________________ Cell phone______________ Home phone_______________

Birthdate______________________ Work phone_____________ Home phone______________

Is this person currently in our office? ( ) Yes ( )No

How did you hear about our office? (Please check all that apply)

( ) Drive-By/Sign ( )Facebook ( ) Former Dentist ( ) Friend/Family (their name: ______________)
( ) Google/Web-site ( )Groupon ( )Insurance Company ( )Moneysaver ( ) New Neighbor Letter

DENTAL INSURANCE INFORMATION: PRIMARY

Insured's name ______________________ Insured's employer_______________________

Insurance Company___________________ Insurance Company Address ________________

Phone#_____________________________ DOB_______________

SS#________________________________ Group#________________________

Local#_____________________________

DENTAL INSURANCE INFORMATION: SECONDARY

Insured's name______________________ Insured's employer__________________

Insurance Company___________________ Insurance Company Address______________________

Phone# __________________ DOB_____________

SS#_____________________ Group #___________________

Local#_________________