Gibbs M. Prevost, Jr., D.D.S.

PATIENT REGISTRATION RECORD

Today's Date: _____ Date of Birth: _____

Name: _____ Social Security #: _____

(Last) (First) (Middle) Driver's License #: _____

Email Address: _____ Residence Phone: _____

Home Address: _____ Emergency Phone: _____

City: _____ State: _____ Zip Code: _____

Sex: _____ Marital Status: _____ Spouse Date of Birth: _____

Spouse's Name: _____ Social Security #: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Who will be responsible for this account? _____

Additional family members on this account: _____

Who referred you to this office? _____

Do you have Dental Insurance? ____

PRIMARY INSURANCE

Insurance Co. _____

Plan #: _____

Policy #: _____ Group #: _____

Do you have secondary Dental Insurance? ____

SECONDARY INSURANCE

Insurance Co. _____

Plan #: _____

Policy #: _____ Group #: _____

I HAVE BEEN GIVEN THE OFFICE APPOINTMENT SHEET AND I HAVE READ AND ACCEPT IT.
Signature: _____

I HAVE BEEN GIVEN THE OFFICE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO IT.
Signature: _____