PATIENT REGISTRATION

ID: Chart ID:

First Name:_____Last Name: _____Middle Initial:__

Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #: _____

E-mail: _____ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist:_____ Preferred Hygienist: _____

Preferred Pharmacy:_____ Referred By: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date:_____

Employer: _____ Insurance Company: _____

Patient (Guardian) Signature: _____ Date: _____

Thompson Family Dentistry
130 Crossroads Plaza
Mt. Pleasant, PA 15666

Authorization to Leave Medical Information on Voicemail

Patient Name: _____

Patient Date of Birth: _____

Preferred Phone Number to Leave Information on: _____

Thompson Family Dentistry providers and their Staff recognize confidentiality as a very important part of your relationship with them. By signing this, you are agreeing to allow us to leave voicemail messages regarding treatment and treatment plans (including the amount the patient would owe on a procedure) on your voicemail.

☐ I authorize Thompson Family Dentistry to leave voicemail messages regarding my treatment or treatment plans at the phone number listed above.

☐ I **DO NOT** want messages regarding my treatment or treatment plans left on my voicemail. Please leave me a message to call your office instead.

This authorization will expire two years from signature unless otherwise indicated below:

☐ Indefinite Ends on Date: _____

Signature: _____ Date: _____