Welcome to Dr. Pamela Weitzel's Dental Practice

PATIENT REGISTRATION

First Name _____Last Name _____Middle Initial _____ Preferred Name _____

Circle one Married Divorced Separated Single Widowed Minor Birth Date _____/_____/_____ Sex: Male / Female

Mailing Address _____

City _____State_____ Zip_____

Home Phone _____Cell _____ Work _____ Ext. _____
Responsible party
if different than patient _____Mailing Address _____

Phone number _____ Work number _____ Ext_____

If patient is minor, parent's name_____

How did you hear about us? _____

Are you a pre medication patient? Yes / No If yes - what medication _____

Employment status: full time part time retired Unemployed

If full time college student, please include the following.

College Name _____Address_____

City _____State_____ Zip Code _____

E-mail Address_____ Do you wish to be contacted by E-mail? Yes / No

Please circle all that apply Responsible party Patient Primary policyholder Secondary policyholder

DENTAL INSURANCE ONLY:

Primary Insurance Policy Holder Name _____ DOB of Policy Holder _____/_____/_____

Name of Insurance Company_____ Insurance Address_____

City_____ State _____Zip _____

Insurance Company Phone_____ Employer Name_____

Employer Phone._____ Employer Address_____

City _____ State _____ Zip _____

ID Number_____ Group Number_____ Relationship to patient _____

Secondary Dental Insurance Policy holder Name _____ DOB of Policy holder _____/_____/_____

Insurance Company_____ Insurance Co Address_____

City_____ State _____.Zip code_____

Insurance Company phone _____Employer Name_____

Employer Phone_____ Employer Address_____

City_____ State _____ Zip code _____

ID Number_____ Group Number_____ Relationship to patient_____