SCHOMMER DENTAL PATIENT REGISTRATION

Welcome!
Thank you for choosing us!
We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient, and cost effective manner possible. The more we know about you, the better we can help you.

Patient's name______________________________________ Nickname___________________
First M.I. Last
Address_____________________________________ Phone(home)_____________ Cell__________

City___________________ State______ Zip______ Phone(work)______________ ext__________

E-mail address_____________________________ Sex ☐ male ☐ female D.O.B_____________
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Parent/Guardian name if patient is a minor____

How would you like to receive appointment reminders? Phone / Text / E-mail (please circle)

In case of an emergency who should we notify? Name_______________ Phone____________

Whom may we thank for referring you?____

Patient's Employer______________________ Occupation______________ SSN#_______________

DENTAL INSURANCE 1st COVERAGE

Employee Name_________________________ D.O.B._____________ SSN#___________________
Insured's Employer________________________ Insurance Co_____________ Ins ID#___________

DENTAL INSURANCE 2nd COVERAGE

Employee Name__________________________ D.O.B._____________ SSN#__________________
Insured's Employer_________________________ Insurance Co_____________ Ins ID#__________

I hereby give permission to Schommer Dental to release any information requested by my insurance company over the course of my treatment. I hereby authorize and direct my insurance benefits to be paid directly to Schommer Dental. I am responsible for any balance not paid by my insurance and for any non-covered services.

Signature_______________________________________ Date___________________