

OAKTON FAMILY DENTISTRY

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PATIENT REGISTRATION

Responsible Party (if someone other than patient)

First name: _____ Last name: _____ Middle Initial: _____
Address: _____
City, State, Zip: _____
Home phone : (____) ____ - _____ Work phone: (____) ____ - _____ Cell: (____) ____ - _____
Birth Date: _____ Soc. Sec: _____
<input type="checkbox"/> Responsible party is also the Policy Holder for Patient
<input type="checkbox"/> Primary Insurance Holder
<input type="checkbox"/> Secondary Insurance Holder

Patient Information. Please PRINT clearly. Thank you.

First name: _____ Last name: _____ Middle Initial: _____
Address: _____
City, State, Zip: _____
Home phone : (____) ____ - _____ Work phone: (____) ____ - _____ Cell: (____) ____ - _____
Birth Date: _____ Age: _____ Soc. Sec: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired
Name of Employer: _____ City, State: _____
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Name of School _____
Email address: _____
Physicians Name: _____ Phone: _____
Main Dental concern: _____
Do you use a pre-medication prior to dental treatment (Anti-biotic)? _____
Who referred you to our office? (Referral Source) _____
EMERGENCY CONTACT _____ Phone: (____) ____ - _____

Insurance Information (please provide insurance card)

Name of Policy Holder: _____
Policy Holder SSN # _____ Policy Holder Birth Date: _____
Policy Holder ID #: _____ Group ID #: _____
Relationship of patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Name of Policy Holder's Employer: _____ City, State: _____
Name of Insurance Company: _____
Address: _____ City, State, Zip _____