Southern Arizona Periodontics, P.L.C.

Periodontics and Dental Implants

PATIENT REGISTRATION

TODAY'S DATE ____________________ EXAMINING DENTIST ☐ EDWARD R. COLE, D.D.S. ☐ SUSAN B. SHARP, D.D.S

☐ MR. ☐ MRS. ☐ DR. ☐ MS. PATIENT NAME ____________________ NICKNAME ____________________

ADDRESS ____________________

CITY ____________________ STATE ____________________ ZIP CODE ____________________

HOME PHONE ____________________ WORK PHONE ____________________ CELL PHONE ____________________

BIRTH DATE ____________________ PATIENT'S SS# ____________________ GENDER ☐ MALE ☐ FEMALE

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE? ____________________

WHO REFERRED YOU TO US? ____________________

PERSON TO CONTACT FOR EMERGENCY ____________________ RELATIONSHIP ____________________ PHONE NUMBER ____________________

CLOSEST RELATIVE NOT LIVING WITH YOU ____________________

ADDRESS ____________________ PHONE NUMBER ____________________

WHO IS YOUR GENERAL DENTIST? ____________________

PRIMARY DENTAL INSURANCE	*SECONDARY DENTAL INSURANCE*
EMPLOYER	EMPLOYER
INSURANCE COMPANY NAME	INSURANCE COMPANY
POLICY HOLDER'S NAME	POLICY HOLDER'S NAME
POLICY HOLDER'S ID (SSN or ID#)	POLICY HOLDER'S ID (SSN or ID#)
BIRTH DATE	BIRTH DATE
OCCUPATION	OCCUPATION
RELATIONSHIP TO POLICY HOLDER	RELATIONSHIP TO POLICY HOLDER
ARE YOU A FULL TIME STUDENT? WHERE	ARE YOU A FULL TIME STUDENT? WHERE

This form MUST be completed prior to your first appointment.

rev 05/08