Southern Arizona Periodontics, P.L.C.

Periodontics and Dental Implants

PATIENT REGISTRATION

TODAY'S DATE _____ EXAMINING DENTIST ☐ 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 _____

EMAIL ADDRESS _____

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 10/14