Dental Associates, Inc.

Dr. Bob Carney Dr. Phil Fisher Dr. Trey Carney

Registration & History Form

Date _____

Birthdate _____

Patient Information **(CONFIDENTIAL)** SS # _____

Name _____ Preferred Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Position _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Person to Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

Which Doctor Will You Be Seeing? _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ SS # _____ Work Phone _____

Are You in Bankruptcy or Contemplating Bankruptcy? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____