Patient Registration

First Name:_____ **Last Name**:_____

Preferred name to be called by our staff:
Address:
City:
State:_____ Zip code:

Emergency Contact:_____**Number**:_____

How would you like to be Confirmed? **We Confirm all patients the day before your appointment; In What order would you like to be contacted in?**

Home:_____
Work:_____
Cell:_____
E-Mail:_____

Insurance Information: Do you have more than One Dental Insurance? Y N
Employer:_____Insurance Company
_____
Who carries the insurance: Self:_____ Spouse:_____
Carriers Name:_____
Carriers Date of Birth:___/____/____
Carriers Social Security Number:_____ID:

Secondary Dental Insurance:
Employer:_____Insurance Company:
_____
Who carries the insurance: Self:_____ Spouse:_____
Carriers Name:_____
Carriers Date of Birth:____/_____/____
Carriers Social Security Number:_____ and ID:

I here by authorize all insurance payments to Brian F. Bottaro, DMD

Signature_____Date:____/____/_____

Name of person responsible to pay your balance if other than your self:
Name:_____
Relationship:_____
Phone Number:_____

Is there anyone else we may discuss your dental health with? Y N
Who:_____ Relationship: _____

Preferred Pharmacy:
Location:_____ Phone number: