MOORE Family Dental
Michael G. Moore DDS

Moore Family Dental PC - PATIENT REGISTRATION *(2018 update)*

First Name: __________________________ Last Name: ____________________________ Middle Initial: ______

Address: ____ E-mail Address: _____________________

City, State, Zip: ____

Home Phone: _______________________ Cell Phone: _____________________ Work Phone: ________________

Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth date: ___________________ **Social Security #:** ____________________ Drivers Lic #: ___________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ F/T or P/T Student

Pharmacy – Phone Number - Address: ____

Referred By: ☐ Internet ☐ Other Patient ☐ Employer ☐ Other ____________________________________

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<u>Responsible Party for Payment</u>: ☐ **SAME AS ABOVE** Relationship to patient: ___________________

First Name: __________________________ Last Name: ____________________________ Middle Initial: ______

Address: ____

City, State, Zip: ____

Home Phone: _______________________ Cell Phone: _____________________ Work Phone: ________________

Birth date: ___________________ **Social Security #:** ____________________ Drivers Lic #: ___________________

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Please indicate the method of payment you will use to pay for dental services provided:

☐ Insurance *(We will prepare and file claim on your behalf.)* ☐ Credit Card ☐ Cash ☐ Personal Check ☐ Care Credit

<u>Dental Insurance Information</u>: ☐ **Delta Dental** ☐ **United Concordia** ☐ **Cigna** ☐ **Other** ________________

Policy Holder Name: _____________________________ Employer: ________________________________

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Parent Insurance Company ___________________________

Policy/Group# __________________________________ Address ___________________________________

Subscriber ID# _________________________________ Ins. Co. Phone #_____________________________

Insured Social Security# ____________________________ **(Use back if you have SECONDARY Dental INSURANCE information.)**

Insured Birth Date _______________________________