Date ___________

Patient Registration

Bryan A Griffith DMD PSC

ABOUT YOU

First Name______________________ Last Name__________________ Middle Initial ____
I prefer to be called ______________ [ ] Male [ ] Female
Address ________________________ ____________________________
City __________________ State ______ Zip: __________
Home Phone _________ Work Phone __________ Ext: ______ Cellular____________
E-mail: ____________________
Marital Status: [ ]Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
Birth Date: __________ Age_______ Soc Sec: ______________
Employer_______________________ Occupation _______________________
Emergency Phone # : _________________
Physician's name _______________________ Physician's phone #________________
Preferred Pharmacy __________________ Pharmacy Phone #__________________

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above
Name: _________________________ D.O.B.____________ Relation:___________
Billing Address: ____________________________ City_________ State_____ Zip__________
Home Phone_________________ Work Phone______________ Ext:_____
Employer____________________ Occupation____________________ S.S. # _____________

DENTAL INSURANCE INFORAMTION

Primary Insurance
Insurance Co. Name_____________________ Phone( ) ___________
Group/Policy # :_______________________
Insured's Name _______________________ Insured's Birth Date __/___/___ Relation__________
Insured's Soc Sec #: ______________________ Insured's Employer____________________

Secondary Insurance
Insurance Co. Name_____________________ Phone( ) ___________
Group/Policy # :_______________________
Insured's Name _______________________ Insured's Birth Date __/___/___ Relation__________
Insured's Soc Sec #: ______________________ Insured's Employer____________________

Please tell us how you heard about Dr. Griffith. Please check all that apply.

( ) Another patient– Name_______________ ( ) T.V. Commercial

( ) Radio ( ) Referral Card ( ) Website ( ) Family/Friend___________

( ) Other ____