DENTAL EXCELLENCE

Stephen M. LaDuque, DDS PA
Patient Registration

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

Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____

Address: _____ Second Address: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

Patient Information

Address: _____ Second Address: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Name of Spouse: _____

Soc. Sec.: _____ Driver Lic.: _____

E-mail: _____ ☐ I would like to receive correspondence via e-mail

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Place of Employment: _____

Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy: _____ Referred by: _____

Contact Information

In case of an Emergency, Please Contact: (Please do NOT put name of person in the same household)

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Date of Birth: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____