DENTAL CARE
of Van Dyke
18930 N Dale Mabry Hwy Suite 102 • Lutz, FL 33548 • O 813.528.8701 • F 813.528.8703

PATIENT REGISTRATION

Patient Information

SECTION 1

First Name:_____ Last Name:_____ M.I.:_____

Address:_____ Suite/Unit/Apt #:_____

City, State, Zip:_____ Home Phone:_____

Work Phone:_____ Ext:_____ Mobile:_____ Pager:_____

Date of Birth:_____ Social Sec.#:_____ Drivers Lic.#:_____

E-mail Address:_____

Whom may we thank for referring you?:_____

SECTION 2

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Child

Employer Name:_____

Employer Address:_____ Employer Phone #:_____

Preferred Pharmacy:_____ Pharmacy Phone #:_____

Emergency Contact (Name & Number):_____

Responsible Party
(if someone other than patient)

☐ Same as Above

First Name:_____ Last Name:_____ M.I.:_____

Address:_____ Suite/Unit/Apt #:_____

City, State, Zip:_____ Home Phone:_____

Work Phone:_____ Ext:_____ Mobile:_____ Pager:_____

Date of Birth:_____ Social Sec.#:_____ Drivers Lic.#:_____

E-mail Address:_____

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

Primary Insurance Information

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

Insured Social Sec. No.:_____ Insured Date of Birth:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

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

Secondary Insurance Information

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

Insured Social Sec. No.:_____ Insured Date of Birth:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

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