Riley Dental Group
FAMILY IMPLANTS | SEDATION

Patient Registration

First Name: _____ Last Name: _____Middle Initial: _____

Preferred Name: _____ Patient is: □Policy Holder □Responsible Party

Patient's Address: _____

City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth Date: _____ Social Security #:_____Driver's License #:_____

Email Address: _____ Employer Name & Address: _____

□ I would like to receive correspondence via email. □ I would like to receive correspondence via text messages.

Responsible Party (If someone other than the patient) Note: If patient is age 18 or older, the patient is the responsible party.

First Name: _____ Last Name: _____ Middle Initial: _____

Patient's Address: _____

City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth Date: _____ Social Security #:_____Driver's License #:_____

Email Address: _____ Employer Name & Address: _____

□ Responsible Party is also a Policy Holder for Patient □Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

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Primary Insurance Information

Name of Insured: _____Relationship to Insured: □Self □Spouse □Child □Other

Employer: _____ Address: _____Ins. Co.: _____

Insured Social Security #: _____Insured Birth Date: _____

Group #: _____Subscriber ID#: _____

Secondary Insurance Information

Name of Insured: _____Relationship to Insured: □Self □Spouse □Child □Other

Employer: _____ Address: _____Ins. Co.: _____

Insured Social Security #: _____Insured Birth Date: _____

Group #: _____Subscriber ID#: _____