Chad S. Burt D. M. D.
Kyle W. Dimond D.D.S.

Patient Registration

Patient Information: **Today's Date:** _____

Name: _____ Nickname: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

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

Email: _____ SocialSecurtiy: _____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Whom may we thank for referring you? _____

Spouse or Responsible Party Information:

Name of Responsible Party (guardian): _____

Address (if different than patient): _____ City, State, Zip: _____

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

Date of Birth: _____ Social Security: _____

Name of nearest relative not living with you: _____

Address: _____ City State, Zip: _____ Phone: _____

Dental Insurance Information:

Insurance Company: _____ Insured Name: _____

Insured DOB _____ Relationship to Patient: _____

Subscriber ID#: _____ Group#: _____ Employer: _____

Insurance Co. Address: _____ Phone: _____

Secondary Dental Insurance Information:

Insurance Company: _____ Insured Name: _____

Insured DOB: _____ Relationship to Patient: _____

Subscriber ID#: _____ Group #: _____ Employer: _____

Insurance Co. Address: _____ Phone: _____