Willard Street Family Dental
willardstreetdental.com
802-862-8625

Patient Registration

I acknowledge I have received a copy of this office's notice of Privacy Practices

_____

Patient signature Date

Patient Information

First name:_____ Last Name:_____Middle Initial_____
Address:_____ Address 2_____
City, State, Zip:_____ Cell Phone_____
Home Phone:_____ Work Phone_____Ext:_____
Sex: ☐ Male ☐ Female Birth Date:_____ Social Security #_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Email Address _____ for appointment reminders ONLY

Responsible Party (ONLY IF PATIENT IS UNDER 18)

First name:_____ Last Name:_____Middle Initial:_____
Address:_____ Address 2_____
City, State, Zip:_____ Cell Phone:_____
Home Phone:_____ Work Phone_____Ext:_____
Birth Date:_____ Social Security #:_____

Primary Insurance information

Policy Holder's Information:
Name_____ Birth Date _____
Address:_____ Address 2:_____
City, State, Zip_____ Social Security #:_____
Employer _____
Insurance Company's Information:
Name _____ Claim's Address:__ _____
Claim's Address 2:_____ _____ City, State, Zip_____
Subscriber ID#_____ Group #_____
Payer ID # _____

Secondary Insurance information

Policy Holder's Information:
Name_____ Birth Date _____
Address:_____ Address 2:_____
City, State, Zip_____ Social Security #:_____
Employer _____
Insurance Company's Information:
Name _____ Claim's Address:_____
Claim's Address 2:_____ City, State, Zip__ _____
Subscriber ID#_____ Group #_____
Payer ID # _____