Lekha Tull, DDS PC

PATIENT REGISTRATION FORM

Section I: **Patient Information** **Date**________________

Name:______________________________ **Salutation:** ______________
Address:__________________________**City:**____________**State:**________**Zip**__________
Phone (______**)**______________ **Work Phone (**_____**)** ______________ **Cell Phone (**______**)**__________
The best time to contact me is:______________☐ **A.M.** ☐ **P.M. on my** ☐ **Home phone** ☐ **Work phone** ☐ **Cell phone**
Sex: ☐ **Female** ☐ **Male** **Date of Birth:**______________ **Social Security Number:**________________
Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**
If Student, Name of School____________________ **City/State** ____________________ ☐ **FT** ☐ **PT**
Spouse or Parent's Name:____________________ **Employer**______________ **Work Phone**__________
Whom may we thank for referring you? ____
Person to contact in case of emergency______________________ **Phone**______________
Email Address__________________________ **Would you like correspondence via email?** ☐ **Yes** ☐ **No**

Section II **Responsible Party**

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**
Name:______________________________ **Relationship to Patient:** ______________
Address:____
City:____________________ **State:**__________ **Zip:**__________ **Phone: (**___**)**______________
Employer________________ **Work Phone (**___**)**______________ **SSN#**______________

Section III **Insurance Information**

Name of Insured______________________DOB____________Relationship to Patient ____________
SSN#:______________ Name of Employer:________________ Work Phone: (____)____________
Address of Employer:______________________City______________State:________Zip __________
Insurance Company____________________ Grp #________________ ID#______________
Ins Co Address:______________________________ Ins Co. Phone:______________

----------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING -----------

Name of Insured______________________DOB____________Relationship to Patient ____________
SSN#:______________ Name of Employer:________________ Work Phone: (____)____________
Address of Employer:______________________City______________State:________Zip __________
Insurance Company____________________ Grp #________________ ID#______________
Ins Co Address:______________________________ Ins Co. Phone:______________