DR. YU & ASSOCIATES

PRACTICING THE FINE ART OF PERIODONTICS & IMPLANTOLOGY

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PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____ Preferred Name: _____

Address:_____

City, State, Zip: _____

Home Phone: _____Work Phone: _____Ext: _____Cell:_____

Birth Date: _____ Soc Sec #:_____ Drivers License: _____

E-mail Address _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other

Emergency Contact Name:_____

Relationship to Patient:_____

Emergency Phone #:_____

Referring Dentist Name: _____

Physician's Name & Phone #: _____

Preferred Pharmacy:

Name:_____ Location (intersection): _____

Responsible Party: (if different than patient)

Relationship to Patient: □ Spouse □ Parent □ Other _____

First Name: _____ Last Name: _____

Address (if different from above):_____

City, State, Zip: _____

Home Phone: _____ Cell:_____

Dental Insurance Information:

Insurance Company Name: _____ Ins. Phone Number: _____

Ins. Company Address: _____

City, State, Zip: _____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. # or Member ID: _____