607-729-4539

PATIENT REGISTRATION

Dr. Jerome T Farrell II DMD

First Name: ______________________ Last Name: ___________________________ Middle Initial ____
Preferred Name: ____
Patient Is: **Policy Holder / Responsible Party**

Responsible Party (if someone other than the patient)
First Name: ______________________ Last Name: _______________________ DOB: _______________
Address: ____
City, State, Zip: ____
Home Phone: _________________ Work Phone: _________________ Cell: ________________________
Social Security: __________________________ Drivers License No: ______________________________
Is this person the: **responsible party is also a policy holder for patient / primary insurance policy holder / secondary insurance policy holder**

Patient Information
Address: ____
City, State, Zip: ____
Home Phone: _______________ Work Phone: _________________ Cell: _________________ Text? **Y / N**
DOB: ___________ Age: __________ Social Security: ______________ Drivers License No: _____________
Sex: **M / F** Marital Status: **Married / Single / Divorced / Separated / Widowed**
Email: ____________________________________ I would like to receive correspondence via email: **Y / N**

Employment Status: **Full Time / Part Time / Retired / Full-time Student / Part-time Student**
Medicaid ID: ___________________ Employer ID: _____________________ Carrier ID: _______________
Preferred Pharmacy? ____

Referred By: ____
Previous Dentist: ____
Emergency Contact & Phone: ____

Primary Insurance Information
Name of Insured: _________________________________ Relationship: **Self / Spouse / Child / Other**
Insured Soc. Sec: _________________________________ Insured Birth Date: ________________________
Employer: _______________________________ Ins. Company: _____________________________
Address: _______________________________ Address: _______________________________
City, State, Zip: ___________________________ City, State, Zip: __________________________
Rem. Benefits: _________ *Rem. Deduct:* ________

Secondary Insurance Information
Name of Insured: _________________________________ Relationship: **Self / Spouse / Child / Other**
Insured Soc. Sec: _________________________________ Insured Birth Date: ________________________
Employer: _________________________________ Ins. Company: _____________________________
Address: _________________________________ Address: _________________________________
City, State, Zip_____________________________ City, State, Zip: ___________________________
Rem. Benefits: _________ *Rem. Deduct:* ________