

Wilson Park Dental

807 St. Andrew Street • Rapid City, SD 57701 • 605-343-9352 • Fax 605-343-3115

PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____
Mailing Address: _____ Physical Address: _____
City: _____ State/Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Employer: _____ # years: _____
Sex: Male Female Marital Status: Married Single
Birth Date: _____ Age: _____ Social Security #: _____
E-mail: _____ I would like to receive correspondences via e-mail
Employment Status: Full Time Part Time Retired Student Status: Full Time Part Time
Emergency Contact Name: _____ Phone: _____ Relationship: _____
Whom may we thank for referring you: _____

RESPONSIBLE PARTY: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Mailing Address: _____ Physical Address: _____
City: _____ State/Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Employer: _____ # years: _____
Birth Date: _____ Social Security #: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Social Security #: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Mailing Address: _____
City, State, Zip: _____ City, State, Zip: _____
Remaining Benefits: _____ Remaining Deductible: _____
Medicaid ID: _____ Employer ID: _____ Carrier ID: _____

BROKEN APPOINTMENT POLICY: We reserve the right to dismiss a patient from our practice for appointments broken without a 24 hour notice.

SIGNATURE OF RESPONSIBLE PARTY: The information I have provided above is accurate to the best of my knowledge.

PAYMENT POLICY: Payment is due at time of service. I elect to pay by: Cash/Check Credit Card Care Credit

Signature: _____ Date: _____