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: _____