Please print this form and bring to your appointment

DR. ELIZABETH A. FARAHBOD
GENERAL & COSMETIC DENTISTRY

Registration

Today's Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

About You

Why have you come to the dentist today? _____

Any Special concerns? _____

Whom we may thank for referring you? _____

Name and Phone #: _____

Patient Information

Address: _____

City, Sate, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ___/___/___ Age _____ SS# _____ Drivers Lic: _____

e-mail: _____ ☐ **I would like to receive correspondences via e-mail**

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time

Student ID: _____ _____

Pref. Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Section 3

Additional Comments:

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, Sate, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: ___/___/___ SS #: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Primary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship: ○ Self ○ Spouse ○ Child ○ Other

Insured ID or SS #: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address : _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Insurance Co. Phone #: _____