JAMES B. POLLEY, DDS

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PATIENT REGISTRATION

Patient Information

Patient: _____ Male ___ Female ___
First Name M.I. Last Name "Goes By"

Home Phone # _____ Work # _____ Cell # _____

Email Address _____ Birth Date _____ SS# _____

Where & When are the best times to reach you? _____

Mailing Address: _____
Street Apt. # City State Zip

Employer _____ Occupation _____

What are some of your hobbies and interests? _____

If Patient is a Child, Father's Name _____ Mother's Name _____

Spouse or Person to Contact in the Event of an Emergency

Name _____ Relationship to Patient _____

Home # _____ Work # _____ Cell # _____ Employer _____

Account Information Is "Patient" also "Person Responsible" Yes____ No ____ If Yes, skip this section

Person Responsible _____ Relationship to Patient _____

Home Phone # _____ Work # _____ Cell # _____

Email Address _____ Birth Date _____ SS# _____

Mailing Address: _____
Street Apt. # City State Zip

Insurance Information Is "Patient" also "Insured" Yes ___ No ___ If Yes, skip to line that begins with *

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Employer _____

*Insurance Company _____ Is there Secondary Insurance? Yes ___ No ___

We'll get the rest of the information about your insurance/benefit plan(s) from your insurance/benefit card(s).

I confirm that all questions have been answered truthfully. I agree to be responsible in full (regardless of insurance/benefit involvement) for all fees for services provided.

Responsible Person's Signature _____ Date _____