

# Family REGISTRATION

## Kosnic & Murphy Dental

kosnicdental

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### Welcome to our Practice

Chart#: \_\_\_\_\_  
FOR OFFICE USE ONLY

Patient Name: \_\_\_\_\_

Last

First

MI

Preferred Name

Title: \_\_\_\_\_

Gender:  Male  Female

Family Status:  Married  Single  Child  Other

Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Prev. Visit: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_

Home

Mobile

Work

Ext

Fax

Other

Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment  both  not applicable

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

### Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for:  the patient's spouse  the person responsible for payment  both  neither-not applicable

Name: \_\_\_\_\_

Last

First

MI

Preferred Name

Title: \_\_\_\_\_

Gender:  Male  Female

Family Status:  Married  Single  Child  Other

Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_

DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_

Home

Mobile

Work

Ext

Fax

Other

Address: \_\_\_\_\_

Address 1

Address 2

City

State

Zip Code

**Primary Dental Insurance:**

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insurance Company Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Secondary Dental Insurance:**

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insurance Company Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Primary Dental Insurance:

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insurance Company Phone Number: \_\_\_\_\_  
\_\_\_\_\_

## Secondary Dental Insurance:

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Insurance Company Phone Number: \_\_\_\_\_  
\_\_\_\_\_