Patient Registration Form

WEIMERSKIRCH FAMILY DENTAL PLLC

Weimerskirch Family Dental, PLLC requests this information for the purposes of providing a complete and comprehensive evaluation of your dental needs. No persons outside this office will be provided this information unless necessary for your care, properly authorized by you, or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in Weimerskirch Family Dental being unable to accept you as a patient. If you have any questions, please do not hesitate to ask. We look forward to having you as a patient!

Patient Information

Legal Name:			SS#
☐ Female ☐ Male	Date of Birth:		Preferred Name:
Street Address:			
City:	State:	Zip:	Phone:
Email:		Preferred contact method: ☐ Text ☐ Email ☐ Phone	
Other immediate family members who are patients:			

Spouse/Parent/Guardian/Emergency Contact

Name:			
Date of Birth:		Relationship to patient:	
Street Address:			
City:	State:	Zip:	Phone:

Dental Insurance/Benefits Information (☐ not applicable)

Please use back page for additional dental benefits, if needed

Policy Holder Name:			SS#
Date of Birth:	Relationship to patient (if other than self):		
Insurance Company:	ID#:	Group#:	
Employer:			

Thank you for your cooperation!