Pipho & Gingrich
Family Dentistry
"Our Family Caring for Yours"

PATIENT REGISTRATION FORM

407 Wilson Street
Dysart, IA 52224
(319) 476-4110

***Today's Date:* _____ *Clinic Name:* Pipho & Gingrich Family Dentistry

PATIENT INFORMATION: (Please use full legal name, no nicknames)

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

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#:** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____) _____-_____

E-mail Address: _____ **Cell Phone #:** (_____) _____-_____

Emergency Contact Name: _____ **Emerg Phone #:** (_____) _____-_____

Please tell us how you heard about us: _____ ***Referred by*** _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient:** **Self** _____ **Spouse** _____ **Parent** _____ **Other** _____

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

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** **Female** _____ **Male** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____)_____-_____

INSURANCE INFORMATION:

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE: **(PLEASE BRING YOUR INSURANCE CARD(S) TO YOUR APPOINTMENT)**

Plan Name : _____ ***Insured's Name:** _____

Insured's Social Security #: _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ **Eff Date:** _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

***Insured's Social Security #:** _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ *** Eff Date:** _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.** **ATTACH COPY OF INSURANCE CARDS**