Welcome!

Sheela Parekh D. D. S. P.A

REGISTRATION FORM

Section I: Patient Information Date_____

Name: _____ I Prefer to be called: _____
Address: _____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (____) _____ Cell Phone (_____)_____
Patient Employer _____
Date of Birth: _____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Date of Birth: _____
Address: _____
City: _____ State:_____ Zip:_____ Phone: (___)_____
Employer_____ Work Phone (___)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (___)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (___)_____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____