BERKSHIRE DENTAL ASSOCIATES, LTD

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Wyomissing, PA 19610
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PATIENT REGISTRATION AND DENTAL HISTORY

Date_____ **(PLEASE PRINT)** Home Phone (____)_____

Patient_____
Last Name First Name Middle Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

E-mail_____ Cell Phone (____)_____
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone ☐Either

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years
If student, Name of School/College_____City_____State_____ ☐ F/T ☐ P/T

Patient Employer _____ Occupation_____

Business Address_____ Business Phone (____)_____

Spouse Name _____ Spouse Birthdate_____

Spouse Employer_____ Occupation_____

Business Address_____ Business Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Patient Social Security #_____ Spouse Social Security #_____

Name of Dental Insurance Company_____ Group Number_____

Name of the Insured_____Policy/ID#_____

Insurance Address_____ Insurance Phone (____)_____

Do you have additional Dental Insurance? ☐ Yes ☐ No If yes, Complete the following:

Name of Insured_____ Relationship to Patient_____

Birthdate_____SS#_____ Union or Local #_____

Name of Employer_____ City_____ State_____

Address of Employer_____ Phone (____)_____

Insurance Company_____ Group#_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____

In case of emergency, who should be notified?_____ Phone (____)_____

Whom may we thank for referring you?_____