LOREE SCHWEIGER NICHOLAS, D.D.S., P.C.

PATIENT REGISTRATION

Date: _____

First Name: _____Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Birth Date: _____ S.S.# _____

E-Mail: _____ (for appointment confirmation & correspondence**: if desired**)

Responsibility Party: (If different than above) _____

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

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ S.S.# _____

E-Mail: _____ (for appointment confirmation & correspondence: **if desired**)

Your Employment Status: FT __ PT __ Retired __

Student Status: FT __PT __ Name of College: _____

Primary Insurance Information:

Named of Insured: _____ Relationship: Self __ Spouse __ Child __Other __
Insured S.S.#: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____ Group #____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____Relationship: Self __ Spouse __Child __Other __
Insured S.S. #: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____ Group #____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____