13590 N MERIDIAN ST
SUITE # 101
CARMEL IN 46032

CARMEL COMPREHENSIVE DENTAL CARE

PHONE: (317) 399-5421
PHONE: (317) 575-1995
FAX: (317) 575-1998

REGISTRATION FORM

PATIENT INFORMATION

Patient Is:	○ Policy Holder ○ Responsible Party (if someone other than the patient)						
First Name:		Last Name:		Middle Initial:		Preferred Name:	

Address:	Address 2:		Home Phone:	Work Phone:	Ext.:
City:	State:	Zip:	Cellular:	Pager:	

E-Mail:		☒ I would like to receive correspondences via e-mail

Birth Date:		Social Security #:		Driver License:	
Gender:	○ Male ○ Female	Marital Status:	○ Married ○ Single	○ Divorced ○ Separated	○ Widowed

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

First Name:		Last Name:		Middle Initial:		Preferred Name:	

Address:	Address 2:		Home Phone:	Work Phone:	Ext.:
City:	State:	Zip:	Cellular:	Pager:	

Birth Date:		Social Security #:		Driver License:	

RESPONSIBLE PARTY IS ALSO

○ Policy Holder for Patient	○ Primary Insurance Policy Holder	○ Secondary Insurance Policy Holder

Employment Status:	Employer ID:		Emergency Contact:	
○ Full-Time	Medicaid ID:		Emergency Phone:	
○ Part-Time	Carrier ID:		Referred By:	
○ Retired	Preferred Pharmacy:		Previous Dentist:	
○ Student	Preferred Dentist/Hygienist:		Confirmation Status:	

PRIMARY INSURANCE INFORMATION

Name of Insured:					
Insured Social Security #:					
Insured Birth Date:					
Relationship to Insured:	○ Self	○ Spouse	○ Child	○ Other	
Employer:			Insurance Company:		
Address:	Address 2:		Address:	Address 2:	
City:	State:	Zip:	City:	State:	Zip:

SECONDARY INSURANCE INFORMATION

Name of Insured:					
Insured Social Security #:					
Insured Birth Date:					
Relationship to Insured:	○ Self	○ Spouse	○ Child	○ Other	
Employer:			Insurance Company:		
Address:	Address 2:		Address:	Address 2:	
City:	State:	Zip:	City:	State:	Zip: