Cory M. Williams DDS PLLC

Patient Registration and Health Information

Patient Information

Patient Name : ______________________________

What you prefer to be called: ______________________________

Street Address: ______________________________

City, State, and Zip Code: ______________________________

Birth Date: ______________ Social Security Number: ______________

Name of School, if student: ______________________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Referred by: ______________________________

Employer: ______________ Occupation: ______________

Employer's Address: ______________________________

Spouse Name: ______________ Spouse's Work Number: ______________

Account Information

Persons ultimately responsibly for the account: ______________________________

Relationship to Patient: ______________________________

Street Address: ______________________________

City, State, and Zip Code: ______________________________

Home Phone: ______________ Work Phone: ______________

Birth date: ______________ Social Security Number: ______________

Employer: ______________________________

Driver's License Number: ______________________________

Payment Method (please check):

____Check ____Cash ____Credit Card ____Care Credit

Dental Insurance Information

Insured's Name: ______________________________

Insured's Employer: ______________________________

Insured's Social Security Number: ______________ Insured's Birth Date ______________

Carrier Name: ______________________________

Group Number: ______________________________

Street Address: ______________________________

City, State, and Zip Code: ______________________________

Phone Number: ______________________________

Emergency Information

Person to contact in case of emergency: ______________________________

Closest relative not living with you: ______________________________

Street Address: ______________________________

City, State, and Zip Code: ______________________________

Phone Number: ______________________________