Snehlata Kulhari DMD, PLLC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	Preferred Name:	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Social Security no.:	Home phone:	Cell phone:
	( )	( )

Street Address:	City:	State:	Zip:

Occupation:	Employer:	Employer phone:
		( )

May we contact you at work, if necessary? ❑ Yes ❑ No

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr.: ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend (name): ❑ Close to home/work ❑ Yellow Pages ❑ Other (please specify):

Other family members seen here:

Email Address:

How would you like to receive reminders about your appointments? ❑ Telephone ❑ Email ❑ Both

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Financial Responsible Party's Full Name:	Birth date:	Main phone Number:
	/ /	( )

Address (if different):

Occupation:	Employer:

Is this person a patient here? ❑ Yes ❑ No

Name of primary insurance:

Subscriber's name:	Subscriber's SSN or ID no.:	Birth date:	Group no.:
		/ /	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell phone no.:
		( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Willis Family Dentistry or insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE	**DATE**