REGISTRATION

1711 NW Grant Ave,
Corvallis, OR 97330
(541) 754-1668

420 Smith St
Harrisburg, OR 97446
(541) 995-8234

Please email completed form to: office@kentburnettdds.com

PATIENT INFORMATION (CONFIDENTIAL)

NAME____DATE__________________

ADDRESS____CITY_________________STATE________ZIP_________

EMAIL____________________________ CELL PHONE_________________ HOME PHONE________________

SS#_____________________BIRTH DATE___________________________SEX ◯ FEMALE ◯ MALE

CHECK APPROPRIATE BOX: ◯ MINOR ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPERATED

PATIENT EMPLOYER/SCHOOL _____________________________________ OCCUPATION_________________________________

EMPLOYER/SCHOOL ADDRESS_____________________________________EMPLOYER/SCHOOL PHONE ________________

WHOM MAY WE THANK FOR REFERRING YOU?____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? ___________________________________PHONE________________

RESPONSIBLE PARTY

IF DIFFERENT THAN ABOVE

NAME ____RELATIONSHIP TO PATIENT__________________

ADDRESS____CITY____________________STATE________ZIP__________

SS#_____________________BIRTH DATE___________________________

EMPLOYER____WORK PHONE_____________HOME PHONE_______________

DRIVER'S LICENSE______________________IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ◯ YES ◯ NO

INSURANCE INFORMATION

NAME OF INSURED____RELATIONSHIP TO PATIENT_______________

SS#_____________________BIRTH DATE_____________________________NAME OF EMPLOYER_________________________

EMPLOYER ADDRESS____CITY_________________STATE________ZIP_________

INSURANCE COMPANY_____________________________PHONE______________GROUP#________POLICY/ID#_____________

INSURANCE COMPANY ADDRESS_____________________________________CITY_____________STATE________ZIP_________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ◯ YES ◯ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED____RELATIONSHIP TO PATIENT_______________

SS#_____________________BIRTH DATE_____________________________NAME OF EMPLOYER_________________________

EMPLOYER ADDRESS____CITY_________________STATE________ZIP_________

INSURANCE COMPANY_____________________________PHONE______________GROUP#________POLICY/ID#_____________

INSURANCE COMPANY ADDRESS_____________________________________CITY_____________STATE________ZIP_________

____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

____

PATIENT NUMBER