L. Wes Turnage, Jr. DMD

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Patient Registration

Patient Information

Name _____ Preferred Name _____

Physical Address _____
Street Number City/State/Zip

Mailing Address _____
Street Number City/State/Zip

❑ Male ❑ Female Date of Birth ____/____/____ ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Home Phone (____) _____ Work Phone (____) _____ Social Security # _____

Cell Phone (____) _____ Pager # (____) _____ E-Mail _____

Employer Name _____ Position _____

Spouse _____ Social Security # _____

Employer Name _____ Position _____

Responsible Party _____ Relationship to Patient _____

Address _____
Street Number City/State/Zip

Home Phone (____) _____ Driver's License #/State _____ Social Security # _____

Employer Name _____ Position _____

Primary Insurance

Insurance Company _____ Group Number _____

Address _____
Street Number City/State/Zip

Name of Insured _____ Insured ID# _____ Insured's Date of Birth ____/____/____

Secondary Insurance

Insurance Company _____ Group Number _____

Address _____
Street Number City/State/Zip

Name of Insured _____ Insured ID# _____ Insured's Date of Birth ____/____/____

Injury/Accident/Other

Is this the result of an accident or injury? ❑Yes ❑No Date of Injury ____/____/____ Attorney, if any _____

❑ Work Related ❑ Auto Related ❑ Other, Explain _____

Worker's Comp. Carrier/Name _____ Phone (____) _____

Miscellaneous Information

Whom may we thank for referring you? _____

Emergency Contact Name/Phone # (not living with you) _____

Family Member / Friends seen by us _____

_____ _____
Patient Signature (or guardian if patient is a minor) Date

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