L. Wes Turnage, Jr. DMD

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Patient Registration

Patient Information

Name _____ Preferred Name _____

Street _____ 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 _____

Employer Address _____
Street Number City/State/Zip

Spouse _____ Social Security # _____

Employer Name _____ Position _____

Employer Address _____
Street Number City/State/Zip

Responsible Party _____ Relationship to Patient _____

Street _____ City/State/Zip _____

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

Employer Name _____ Work Phone (___) _____

Employer Address _____
Street Number City/State/Zip

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 gaurdian if patient is a minor) Date

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