



MARTIN DENTISTRY

Broad Ripple & Fishers

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____	Last Name: _____	Middle Initial: _____
Address: _____		Address 2: _____
City, State, Zip: _____		Pager: _____
Home Phone: _____	Work Phone: _____	Ext: _____ Cell: _____
Birth Date: _____	Soc. Sec: _____	
<input type="checkbox"/> Responsible Party is also a Policy Holder for Patient <input type="checkbox"/> Primary Insurance Policy Holder <input type="checkbox"/> Secondary Insurance Policy Holder		

Patient Information

First Name: _____	Last Name: _____	Middle Initial: _____
Address: _____		Address 2: _____
City, State, Zip: _____		Pager: _____
Home Phone: _____	Work Phone: _____	Ext: _____ Cell: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Birth Date: _____	Age: _____	Soc. Sec: _____
E-mail: _____	<input type="checkbox"/> I would like to receive correspondences via e-mail	
In case of emergency contact: _____	Phone Number: _____	

Primary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Remaining Benefits: _____ .00	Remaining Deductible: _____ .00

Secondary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Remaining Benefits: _____ .00	Remaining Deductible: _____ .00

Signature: _____ Date: _____



Complete Family and Cosmetic Dentistry

At our office we would like your experience to be a pleasant one. We would like you to feel comfortable while you are here and feel comfortable referring your friends and family. We offer a wide range of dental services: cleanings, periodontal treatment (for gum disease), white fillings, crowns, and same-day crowns, bridgework, veneers and tooth whitening, implant services, tooth removal, root canals, dentures and much more.

It is not surprise that the dental office is not everyone's favorite place to visit. Our goal is to change that opinion. Please help us to serve you better by answering the following questions.

What did you like or dislike about your last dental office?

What is your main concern for today's visit?

Is there anything about your smile that you would like to change?

What would you like to learn more about?

Do you have any suggestions?

How did you hear about us?

Person who referred you? _____