**Keowee Family Dentistry, PA**

Michael H. Davis, DMD, FAGD

15680 Wells Hwy
Seneca, SC 29678

Scott Reid, DMD

Phone: (864) 885-9585 Fax: (864) 885-0975

Patient ID#: _____

## Patient Registration

Patients Full Name: _____ Name you prefer to be called: _____

| Street/ PO Box: | | Address 2: |
|---|---|---|
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: |

Sex: ____Male ____Female Marital Status: ___Married ___Single ___Separated ___ Divorced ___ Widowed

Birth Date: _____ Age: _____ Social Security Number: _____

Employer: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Do you have any Immediate Family Member/s that are patients with us? _____ Yes _____ No
If yes, please tell us their names: _____

Referred to our office by: _____

Preferred Dentist: _____ Preferred Hygienist: _____

Preferred pharmacy: _____ Pharmacy Phone #: _____

**Responsible party for this account (<u>This person will also sign the Financial Policy</u>)**

First Name: _____ Last Name: _____ Relation to patient: _____

Street/PO Box: _____ Address 2: _____

City, State, Zip: _____ Phone #: _____ Birth Date: _____

**Primary Insurance**

Name of Policy Holder: _____ Relation to patient: _____

Employer: _____ Employer Phone #: _____

Group #: _____ ID #: _____ Name of Insurance Company: _____

Policy Holder Address: _____

Policy Holder Birth Date: _____ Policy Holder SSN: _____

**Secondary Insurance**

Name of Policy Holder: _____ Relation to patient: _____

Employer: _____ Employer Phone #: _____

Group #: _____ ID #: _____ Name of Insurance Company: _____

Policy Holder Address: _____

Policy Holder Birth Date: _____ Policy Holder SSN: _____

By Signing below, I hereby authorize any advisable dental procedures, x-rays, medications or anesthetics to be administered by the dentist or staff for diagnostic purposes or dental treatment for the above listed patient.

**Patient/Guardian Signature:** _____ **Date:** _____