Advanced Dental Artistry
Restorative & Esthetic Dentistry

Brett A. Wallen, DDS

Patient Registration

PATIENT NAME (Last, First, Middle Initial) **(Preferred Name)**		DATE OF BIRTH
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS ☐ Single ☐ Married
HOME PHONE	***CELL PHONE**	SEX ☐ Male ☐ Female
DO YOU PREFER: ☐ Morning Appointments ☐ Afternoon Appointments		RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child
EMPLOYER		WORK PHONE
OCCUPATION		
***EMAIL ADDRESS**		

Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Referred to this office by:

NAME	PHONE

Insurance Information

Primary Coverage	Secondary Coverage
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION