Kimberly A. Thomas, DDS

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separate ☐ Widow ☐ Partner ☐ Yrs
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Gender ☐ F ☐ M
Street address:		Social Security no.:			Home phone : ( )
City:	State:	ZIP Code:			Work phone : ( )
Occupation:	Employer:				Cell phone: ( )
E-mail:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance:				Phone no.: ( )
Subscriber's name:	Subscriber's S.S.N.:			Birth date:
Employer:	Group no.:			
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Is this patient covered by additional insurance? ☐ Yes ☐ No

Insurance:				Phone no.: ( )
Subscriber's name:	Subscriber's S.S.N.:			Birth date:
Employer:	Group no.:			
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other