BURNS FAMILY DENTISTRY
2010 E. 70th Street • Shreveport, LA 71105 OFFICE 318-798-3000 FAX 318-798-3044 EMERGENCIES 318-461-3028
WEB www.BurnsFamilyDentistryShreveport.com OFFICE HOURS Mon, Wed, Thurs 8–5 • Tues 8–6 • Fri 8–11am

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: _____ Cellular: _____

Birth Date: _____ Social Security #:_____ Drivers License #: _____

◯ Responsible Party is also a Policy Holder fro Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Social Security #:_____ Drivers License #: _____

E-mail: _____ ☐ I would like to receive correspondence via e-mail

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Preferred Dentist: _____

Employer ID: _____ Preferred Pharmacy: _____

Carrier ID: _____ Preferred Hygienist: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deductible: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deductible: _____.00