Date _____

Brookside Dental Care

Bryan A. Griffith DMD

Patient Registration

ABOUT YOU

First Name_____ Last Name_____ Middle Initial ____
I prefer to be called _____ [ ] Male [ ] Female
Address _____ _____
City _____ State _____ Zip: _____
Home Phone _____ Work Phone _____ Ext: _____ Cellular_____
E-mail: _____
Marital Status: [ ]Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
Birth Date: _____ Age_____ Soc Sec: _____
Employer_____ Occupation _____
Emergency Contact : _____ Phone #_____
Physician's name _____ Physician's phone #_____
Preferred Pharmacy _____ Pharmacy Phone #_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above
Name: _____ D.O.B._____ Relation:_____
Billing Address: _____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Ext:_____
Employer_____ Occupation_____ S.S. # _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name_____ Phone( ) _____
Group/Policy # :_____
Insured's Name _____ Insured's Birth Date __/___/___ Relation_____
Insured's Soc Sec #: _____ Insured's Employer_____

Secondary Insurance
Insurance Co. Name_____ Phone( ) _____
Group/Policy # :_____
Insured's Name _____ Insured's Birth Date __/___/___ Relation_____
Insured's Soc Sec #: _____ Insured's Employer_____

☐ If you would like to give us permission to discuss information about you (treatment, appointments, dental conditions, financials, etc.) with someone else, please check this box.

Please tell us how you heard about Dr. Griffith. Please check all that apply.

( ) Another patient– Name_____ ( ) T.V. Commercial

( ) Radio ( ) Referral Card ( ) Website ( ) Family/Friend_____

( ) Other _____