

Angell Street Dental Associates
425 Angell Street
Providence, Rhode Island 02906

PATIENT REGISTRATION

Date _____

Patient's name: _____ Birthdate _____ Sex: M F

Address: _____ Apt # _____ Marital status S M D W

City _____ State _____ Zip Code _____

E-mail address _____ Home phone () _____

Work phone () _____ EXT _____ Cell Phone () _____

SS# _____ Name of spouse, if applicable _____

If you are a full time student, Name of school _____

Employed by _____ Occupation _____

Who recommended you to our office? _____

Person Responsible for this account (if different from above)

Relationship to patient () Self () Spouse () Parent/Guardian () Other (If self, please skip to insurance section)

Name _____ Birthdate _____ Sex M F

Address _____ Apt _____ E-Mail _____

City _____ State _____ Zip Code _____

SS# _____ Home phone _____ Cell phone _____

Work phone _____ Ext _____ Employer _____

Is Patient Covered by Dental Insurance? () Yes () No

Employee's Name _____ Birthdate _____ Sex M F

SS# or subscriber number (shown on card) _____

Employers Name _____ Insurance Company _____

Address of Insurance Company _____

Relationship to patient () Self () Spouse () Parent/Guardian () Other Group # _____

Is patient covered by another dental insurance? () Yes () No

Secondary Dental Insurance

Employee's Name _____ Birthdate _____ Sex M F

SS# or subscriber Number (shown on card) _____

Employer's name _____

Insurance Company _____

Address _____

Relationship to Patient () Self () Spouse () Parent/Guardian () Other Group # _____

NOTE: Due to constantly changing rules, regulations, benefits and deductibles, we are only able to estimate your insurance payment and your co-payment. If your insurance pays less than is actually due for your services, you will be responsible for the difference. If your insurance pays more than is actually due, you will be credited the difference. Final responsibility for payment will rest on you, when you sign this form.

Date _____ Signature _____ Relationship to patient _____

