WELLNESS
BIODENTISTRY

Patient Registration

Patient Name: _____ Date of Birth: _____

Prefer to be called: _____ ☐ Male ☐ Female SSN:_____

☐ Married ☐ Single ☐ Minor child ☐ Divorced ☐ Widowed

Mailing address:_____ City, State, Zip:_____

Physical address (no PO box):_____ City, State, Zip: _____

Email address: _____ Cell phone:_____

Work phone: _____ Employer:_____

Home phone: _____May we send appointment reminders by text? _____

SPOUSE (or if patient is a minor, other parent)

Name:_____ Cell phone:_____

Work phone:_____ Employer:_____

EMERGENCY CONTACT (if other than spouse listed above)

Name:_____ Cell phone:_____

Other phone:_____ Relationship to patient:_____

DENTAL INSURANCE (If you do not have DENTAL insurance, you may skip this section

Primary insurance

Insurance company name:_____ State:_____

Policyholder name:_____ Relationship to patient:_____

Policyholder date of birth: _____ Policyholder SSN:_____

Policyholder ID:_____ Group number:_____

Secondary insurance, if applicable

Insurance company name:_____ State:_____

Policyholder name:_____ Relationship to patient:_____

Policyholder date of birth: _____ Policyholder SSN:_____

Policyholder ID:_____ Group number:_____

The information I have given today is correct to the best of my knowledge. I authorize payment directly to Wellness BioDentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment, and that it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize Jordan C Baker, DDS AIAOMT and the associates or employees of Wellness BioDentistry to perform any dental services I may need during diagnosis and treatment with my informed consent.

Signature_____ Relationship to patient_____ Date_____