



## PATIENT REGISTRATION

Patient is:  Responsible Party  Insurance Policy Holder  Dependent (Child)

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### PATIENT INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I would like to receive correspondence via Text and Email.

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Insurance:  Primary Ins. Policy Holder  Secondary Ins. Policy Holder

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### RESPONSIBLE PARTY INFORMATION (if someone other than the patient):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I would like to receive correspondence via Email.

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### PATIENT INFORMATION CONTINUED:

[www.DentalWellnessCenterGA.com](http://www.DentalWellnessCenterGA.com)

DWC of JESUP  
135 Peachtree Street  
Jesup, GA 31545  
912.427.2660 -Office  
912.427.8158 -Fax  
dwcj@live.com

DWC of RICHMOND HILL  
10104 Ford Avenue; Suite G  
Richmond Hill, GA 31324  
912.445.5337 -Office  
888.289.4301 -Fax  
dwcrh@live.com

DWC of SAVANNAH  
14045 Abercorn Street, Suite 2403  
Savannah, GA 31419  
912.920.5577- Office  
912.226.3489 -Fax  
dwcsav@live.com

DWC on PAULSEN  
5209 Paulsen Street  
Savannah, GA 31405  
912.355.1512- Office  
912.355.1218- Fax  
dwcpcaulsen@outlook.com

\*RH -10/01/2017\*bnT

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Preferred Dentist: \_\_\_\_\_ Preferred Hygienist: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

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**PRIMARY INSURANCE INFORMATION:**

*(Please provide our front desk with your insurance card so that we may have a copy on file.)*

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Dental Insurance Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Co.: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Contact #: \_\_\_\_\_ Contact #: \_\_\_\_\_

Summary of Benefits: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deductible: \_\_\_\_\_

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**SECONDARY INSURANCE INFORMATION:**

*(Please provide our front desk with your insurance card so that we may have a copy on file.)*

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Dental Insurance Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Co.: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Contact #: \_\_\_\_\_ Contact #: \_\_\_\_\_

Summary of Benefits: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deductible: \_\_\_\_\_