



Andrea M. Taliento, DMD

PATIENT REGISTRATION FORM

Patient Contact Information

Title____Patient's name____Nickname____
Social Security Number:____Date of birth____Sex: Male Female Other____
Marital Status: Single Married Divorced Widowed Pronouns:____
Street address/PO box____City/State____
Zip____Email address____
Home phone____Cell phone____Work____Ext.____
I prefer calls at Home Work Cell Preferred Pharmacy____
Emergency Contact____Relation____Phone____
If full time college student: State____Name of School____
Person responsible for payment of this account:____
Social security number____Date of Birth____
Street address/PO Box_City/State_Zip____
How did you hear about us?____If referred here, who?____

Patient Employment Information

Employer____Occupation____Since____
Street address/PO Box____City/State____Zip____

Dental Insurance Information

Insurance Company Name:____
Street address/PO Box____City/State____Zip____
Certificate, Group, or Policy #____
Policyholder name____Relation to patient____
Policyholder's Social Security or ID #:____Policyholder's Date of Birth____
Policyholder's address____
Policyholder's employer____

I understand that it is my responsibility to submit my claim information to the insurance company, and I am responsible for the full fee at time of service.

Signature required____Date____