Welcome to Schutze Family Dentistry P.C.

Please complete our registration form, so that we may better serve your dental insurance needs.
Thank you!

DATE_____

Patient's Name_____Nickname_____
Soc. Sec. #_____ Birth date_____
Address_____ Home phone_____
City_____ State_____ Zip_____ Cell phone_____
Sex: M F Single Married Divorced Widowed Other_____

Employer _____ Business phone_____
Business address_____ Occupation_____
Spouse name_____ Employer_____ Business phone_____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone_____
(relationship)
When confirming your appt.,where can we speak with you? _____Phone_____

PRIMARY DENTAL INSURANCE

Subscriber_____ Subscriber's birth date_____
Subscriber's Soc Sec. #_____ Relationship to patient_____
Subscriber's address_____ Home phone _____
City_____ State_____ Zip_____ Cell phone_____

Subscriber employed by_____ Business phone_____
Business address_____ Occupation_____
Dental Insurance Company_____
Insurance Company Address_____
Subscriber I.D. #_____Group #_____ Who's covered?_____

ADDITIONAL DENTAL INSURANCE

Subscriber_____ Subscriber's birth date_____
Subscriber's Soc Sec. #_____ Relationship to patient_____
Subscriber's address_____ Home phone _____
City_____ State_____ Zip_____ Cell phone_____

Subscriber employed by_____ Business phone_____
Business address_____ Occupation_____
Dental Insurance Company_____
Insurance Company Address_____
Subscriber I.D. #_____Group #_____ Who's covered?_____