# Adrian Guerra, DDS

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Med Alert
Drug interactions
Premed
Allergies

## Patient Registration Form

***Note: The information on this form is necessary for quality, comprehensive care. It is (of course) strictly confidential and in compliance with "HIPPA" The Health Insurance Patient Protection Act.***
***Please complete all parts, checking all areas and circling as appropriate.***

Name: (Mr. Mrs. Ms. Dr.) _____ Marital Status: M/D/S/W Spouse Name:_____

Date of Birth: _____Age: _____ Home Phone# _____Cell # _____

Email Address: _____Drivers License_____ ***(Please give receptionist to copy)***

Florida Address: _____ City _____ Zip _____

Northern Address: _____ City _____ Zip _____

Residency: Permanent or Seasonal From: _____ To: _____

Employment Status: Full time _____ Part time ____ Student ___ School _____ Retired _____

Occupation: _____ Employer Name: _____

Employer Address: _____ Employer Phone # _____

Dental Insurance? _____ Insurance Company? _____Insurance provided by _____

Insurance company Address: _____ City _____ Zip _____

Phone # _____ Group # _____ ***(Please give receptionist to copy)***

Name and SS# of subscriber _____ Date of birth of subscriber _____

Relationship to Subscriber: **Self / Spouse / Child** Do you have secondary insurance? Yes/No

Reason for your visit today? _____

Whom may we thank for referring you to our dental office? _____

***I certify that I have read and understand the above. I acknowledge that the questions set forth above have been answered to my satisfaction. I will not hold Dr. Guerra or his staff responsible for any errors or omissions that I have made in the completion of this form. I am responsible for payment of all services rendered by this office regardless of insurance coverage.***

Signature of Patient/***Responsible Party***: _____ Date: _____

Signature of Staff: _____ Date: _____