



BAY COSMETIC DENTISTRY  
JEFFREY V. SCHROEDER, D.D.S.  
RICHARD P. SABLE, D.D.S.  
MICHAEL R. SCHER, D.D.S.

## PATIENT REGISTRATION

### PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MIDDLE LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ EMAIL \_\_\_\_\_

SELECT ONE:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

IF COLLEGE STUDENT Full-Time / Part Time (circle one) NAME OF SCHOOL \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT/GUARDIAN NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

### RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DRIVERS LICENSE # \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO



BAY COSMETIC DENTISTRY  
JEFFREY V. SCHROEDER, D.D.S.  
BRANDON MACK, D.D.S.  
MICHAEL R. SCHER, D.D.S.

## PATIENT REGISTRATION

### INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

INS CO ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CO \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

INS CO ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR)

\_\_\_\_\_  
DATE