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 (CONFIDENTAL)

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 **NAME OF SCHOOL** ____________________________
(circle one)

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**

3716 W. Neptune, Tampa, FL 33629
P: (813) 254-1007 / F: (813) 254-1177

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

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