Gallery57

Andrew C. Koenigsberg, D.D.S.
Lee E. Wexler, D.D.S.

patient registration

Last Name ____________ First Name ____________ Middle Initial ______

Birth Date ____________ Preferred Name ____________

Salutation: Mr. Mrs. Ms. Dr.   Marital Status: Single Married Partnered Widowed Divorced

Street Address ____________ Apt.___ City__________ State _____ Zip ______

Home Telephone ____________ Work Telephone ____________ ext. ______

Mobile ____________ e-mail ____________

How would you prefer to be contacted? Home tel. Work tel. Cell e-mail

Do you have a preferred appointment time (day and/or time)? ____________

Emergency Contact ____________ Phone ____________

Whom may we thank for referring you? ____________

Do we treat any other members of your family? ____________

The purpose of my visit is ____________

If you have dental benefits and would like us to generate a form for you, please provide the following information.

Employer ____________ Address ____________

Insurance Company ____________ Address ____________

Policy Number ____________ Social Security Number ____________

If you have dental benefits through a family member and would like us to generate a form for you, please provide the following information.

Name of Insured: Last ____________ First ____________ Middle Initial ______

Relationship to insured ____________ Policy Number ____________

S.S. Number of Insured ____________ S.S. Number of Patient ____________

Employer ____________ Address ____________

Insurance Company ____________ Address ____________

If patient is a minor or someone other than the patient if responsible for the account, please provide the following information.

Name of Responsible Party ____________ Relationship ____________ Tel. ______

Street Address ____________ Apt.___ City__________ State _____ Zip ______

Signature of guardian (for patients under eighteen) ____________ Date ______

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Date ____________ Signature ____________