BROOKSIDE DENTISTRY

Luke A. Foster, DDS
Chia-Yin Lo, DDS

Registration Form

Please circle: Mr. Ms. Mrs. Mx. Dr.

Patient name ____ Date of birth _________________ Sex ______________

Preferred name _______________________________

Whom may we thank for referring you? ____

Person responsible for the account

Name ____

Address ____

City, State, Zip ____

Home phone ____________________ Cell phone __________________Work phone___________________ Ext.______

Which number works best to reach you? ☐ Home ☐ Cell ☐ Work Which time of day?___________________________

Email ____ ☐ I would like to receive correspondence via email

Date of birth _____________________ Social security number ________________________

Employer ____ Occupation ______________________________

Patient information(if different)

Address ____

City, State, Zip ____

Phone ____

Emergency contact

Name ______________________________ Relationship to patient ______________ Phone ______________________

Dental Insurance Information (Please bring your insurance card with you to your appointment)

Primary

Subscriber name ________________________ Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Subscriber date of birth ____________________ Subscriber/Member ID # ________________________________

Name of insurance carrier ________________________ Group # _________________

Secondary

Subscriber name _________________________ Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Subscriber date of birth _____________________ Subscriber/Member ID # ________________________________

Name of insurance carrier _________________________________ Group # _________________