Perri Kauls, D.D.S.
Robert Marolt, D.D.S.
12 Long Lake Road
Number 12
Mahtomedi, MN 55115
651-770-2699
www.orcharddentalgroupmn.com

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Today's Date____________________

NAME_________________________________PREFERS TO BE CALLED BY___________________
LAST FIRST M.I.
HOME #_____________________ CELL #___________________ WORK #___________________
ADDRESS________________________ CITY____________________STATE_______ ZIP________
BIRTHDATE_____________________ SOCIAL SECURITY#______________ __MALE __FEMALE
E-MAIL ADDRESS________________________CHECK APPROPRIATE BOX: __SINGLE __MARRIED
CONTACT PREFERENCE (Check one) ___HOME # ___WORK # ___CELL # ___TEXT MESS. ___E-MAIL

IS ANOTHER MEMBER OF YOUR FAMILY OR A RELATIVE A PATIENT AT OUR OFFICE?

NAME____________________________________RELATIONSHIP_________________________
LAST FIRST M.I.
EMERGENCY CONTACT: NAME________________ RELATIONSHIP__________ PHONE___________
HOW DID YOU LEARN ABOUT US? __ REFERRAL, _______________________LOCATION, __ OTHER
(NAME)

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME__________________________________ RELATIONSHIP TO PATIENT__________________
ADDRESS______________________________ CITY___________ STATE____ ZIP______________
PHONE # (DAY)_____________________ (NIGHT)_______________ E-MAIL__________________
SOCIAL SECURITY #______________ DATE OF BIRTH___________ OCCUPATION_______________
EMPLOYER'S NAME________________________ EMPLOYER'S PHONE #______________________
ADDRESS_________________________ CITY_________________ STATE______ ZIP___________

PRIMARY DENTAL BENEFITS (INSURANCE)

INSURANCE COMPANY_____________________GROUP #_______________ID#_______________
EMPLOYER'S NAME______________________________ EMPLOYER'S PHONE #_______________
INSURED'S NAME_________________________ RELATIONSHIP TO PATIENT__________________
INSURED'S SOCIAL SECURITY #______________________ INSURED'S DATE OF BIRTH___________

SECONDARY DENTAL BENEFITS (INSURANCE)

INSURANCE COMPANY_____________________GROUP #_______________ID#_______________
EMPLOYER'S NAME______________________________ EMPLOYER'S PHONE #_______________
INSURED'S NAME_________________________ RELATIONSHIP TO PATIENT__________________
INSURED'S SOCIAL SECURITY #______________________ INSURED'S DATE OF BIRTH___________