Pediatric Dentistry of San Angelo - Kelly Sawyer, DDS, PA
Patient Registration

PATIENT INFORMATION

Full Name: ______________________________ Preferred Name: ______________

Address: ______________________ City: ____________ State: ___ Zip: _____

Home Phone: ____________ Birth Date: __________ Age: _____ Sex: O Male O Female

Soc Sec: ______________ Email Address: __________________________

RESPONSIBLE PARTY INFORMATION (*will be contacted for appointment reminders*)

Full Name: ______________________________ Relationship to Patient: ___________

Address: ______________________ City: ____________ State: ___ Zip: _____

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Birth Date: __________ Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Soc Sec: ______________ Email Address: __________________________

INSURANCE INFORMATION

□ Check if **NO DENTAL INSURANCE** **(2ndry Insurance Information on back)**

Insured Full Name: ______________________________ Relationship to Patient: ___________

Address: ______________________ City: ____________ State: ___ Zip: _____

Home Phone: ______________ Work Phone: ______________ Sex: O Male O Female

Birth Date: ______________ **Policy #:** ______________ **Group #:** ______

Soc Sec: ______________ **Ins Phone**: ______________

Employer: ______________ Claims Address: ______________

Insurance Name: ______________ City, St, Zip: ______________

OTHER INFORMATION

Emergency Contact: ______________________

Emergency Phone Number: ______________________

Relationship to Patient: ______________________

Previous Dentist: ______________________

Preferred Pharmacy: ______________________

Street: ______________________

Child's past dental experience: ______________________

____

How did you hear about our office??
REFERRED BY (check one):

□ Doctor/Dentist: ______________________

□ Phone Book: ______________________

□ Friend: ______________________

□ PDSA Staff: ______________________

□ School or Daycare: ______________________

□ Noticed Building
□ Newspaper Ad
□ County Map
□ PDSA Website
□ Google
□ Goodfellow.com
□ San Angelo Family Magazine
□ Goodfellow AFB Guide
□ City Map
□ Concho Valley Home Page
□ Facebook (Kelly Sawyer DDS)

*****As a courtesy, a claim will be filed to your insurance.**
The *estimated* patient portion is due when services are performed. ***

Find us on Facebook : Kelly Sawyer DDS

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Patient Registration (CONTINUED)

PATIENT INFORMATION – 2nd Child

Full Name: ____ Preferred Name: ______________________

Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Home Phone: ______________________ Birth Date: ________________ Age: _______ Sex: O Male O Female

Soc Sec: _________________________ Email Address: ____

PATIENT INFORMATION- 3rd Child

Full Name: ____ Preferred Name: ______________________

Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Home Phone: ______________________ Birth Date: ________________ Age: _______ Sex: O Male O Female

Soc Sec: _________________________ Email Address: ____

PATIENT INFORMATION- 4th Child

Full Name: ____ Preferred Name: ______________________

Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Home Phone: ______________________ Birth Date: ________________ Age: _______ Sex: O Male O Female

Soc Sec: _________________________ Email Address: ____

SECONDARY INSURANCE INFORMATION (if applicable)

Insured Full Name: ____ Relationship to Patient:_______________

Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Home Phone: ________________________ Work Phone: ______________________ Sex: O Male O Female

Birth Date: ______________________ **Policy #:** ______________________**Group #:** _________

Soc Sec: ________________________________ **Ins Phone**: _____________________________________

Employer: _______________________________ Claims Address: __________________________________

Insurance Name: __________________________ City, St, Zip:____________________________________

: Kelly Sawyer DDS