Piedmont Family Dentistry
181 W. WILKES MEDICAL CENTER
RD. FERGUSON, NC 28624
336-973-5060

REGISTRATION FORM **Date_____**

Section 1 Patient Information

Name: _____ Preferred Name: _____

Address: _____City:_____State:_____Zip_____

Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____

Date of Birth: _____ Social Security Number:_____ ☐ You can contact me at work

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School: _____ City/State: _____ ☐ FT ☐ PT

Spouse or Parent's Name: _____ Employer: _____Work Phone:_____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you? _____

Email Address: _____ Would you like to receive our e-notifications? ☐ Yes ☐ No

Section 2 Responsible Party

Relationship to Patient: ☐ Self (Skip to Section 3) ☐ Spouse ☐ Parent ☐ Other _____

Name:_____

Address: _____

City: _____ State:_____ Zip:_____ Phone: (____)_____

Employer: _____ Work Phone: (____)_____ SSN#: _____

Section 3 Dental Insurance Information

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#:_____ Name of Employer: _____ Work Phone: (____)_____

Address of Employer: _____ City:_____State:_____Zip:_____

Insurance Company: _____ Grp #: _____ ID#: _____

Ins Co Address: _____ Ins Co. Phone:_____