# Christine J. Coke, D.D.S., M.D., PA

## PATIENT REGISTRATION

In order for us to file insurance claims correctly, please fill in all information.
**All patient information is confidential**.

**PATIENT INFORMATION:** Today's Date: _____

First Name_____ M.I. _____ Last Name_____

☐ Male ☐ Female Preferred Name_____ Birth Date_____ Social Security #_____

Home Address_____ City_____ State_____ Zip_____

Main Tel. (_____) _____ Additional Tel. (_____) _____ E-mail_____

Employer_____ Employer Address _____ Work Tel. (_____) _____

Emergency Contact_____ Tel. (_____) _____ Relationship_____

**PRIMARY RESPONSIBLE PARTY** (Check one): ☐Self ☐ Mother ☐ Father ☐ Other: _____

First Name _____ M.I. _____ Last Name _____

Home Address_____ City _____ State _____ Zip _____

Main Tel. (____) _____ Additional Tel. (_____) _____ E-mail _____

Social Security #_____ Birth Date _____ Employer _____

Employer Address _____ Work Tel. (_____) _____

**OTHER RESPONSIBLE PARTY INFORMATION** (**example, other parent**) (Check one): ☐ Self ☐ Mother ☐ Father ☐Other: _____

First Name _____ M.I. _____ Last Name _____

Home Address_____ City _____ State _____ Zip _____

Main Tel. (____) _____ Additional Tel. (_____) _____ E-mail _____

Social Security #_____ Birth Date _____ Employer _____

Employer Address _____ Work Tel. (_____) _____

**PRIMARY DENTAL INSURANCE**

Insurance Company _____

Insurance Co. # (_____) _____

Policyholder's Employer _____

Policyholder's Name _____

Policyholder's DOB _____

Relationship to Patient _____

**PRIMARY MEDICAL INSURANCE**

Insurance Company _____

Insurance Co. # (_____) _____

Policyholder's Employer _____

Policyholder's Name _____

Policyholder's DOB _____

Relationship to Patient _____