# Clear Comfort Dental

Office of Cherine K. Quan, DMD, PC

## REGISTRATION FORM

Date _____ Email _____

### PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First name

Address _____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____Work Phone(_____)_____-_____

Sex __M __ F Age _____ Date of Birth _____/_____/_____ __Single __Married __Widowed__Seperated__Divorced

Patient Employed by _____ Occupation_____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone(___)_____-_____

### PRIMARY INSURANCE

Person Responsible for Account _____ Phone # (_____)_____-_____

Relation to Patient _____ Date of Birth _____/_____/_____ Soc. Sec. # _____

Address(if different from patient's) _____

Person Responsible Employed by: _____ Occupation _____

Business Address _____ Business Phone (_____)_____-_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

### ADDITIONAL INSURANCE

Is patient covered by additional Ins? __Yes __No Subscriber Name _____

Relation to Patient _____ Date of Birth _____/_____/_____ Phone # (_____)_____-_____

Address (if different from patient's) _____

Subscriber Employed by _____ Business # (_____)_____-_____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____