Dr. Radu Pop, DMD

REGISTRATION AND TREATMENT

Date: _____

Home Phone ( ) -

Cell Phone ( ) -

PATIENT INFORMATION

Name: _____ SS/HIC/Patient #: _____

Last Name First name Middle Initial

Address: _____ Email: _____

City: _____ State: _____ ZIP Code: _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: ( )

Whom may we thank for referring you? _____

In case of emergency who should be notified? Phone: ( )

PRIMARY INSURANCE

Person responsible for account: _____

Last Name First name Middle Initial

Relation to Patient: _____ Birth date: _____ ID#/Soc. Sec. #: _____

Address (if different from patient's): _____ Phone: ( )

City: _____ State: _____ ZIP Code: _____

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 insurance? ❑ Yes ❑ No

Subscriber Name: _____ Relation to Patient: _____ Birthdate: _____

Address (if different from patient's): _____ Phone: ( )

City: _____ State: _____ ZIP Code: _____

Subscriber Employed By: _____ Business Phone: ( )

Insurance Company: _____ Soc. Sec. #: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan:

Please Complete Above Information with History & Authorization Page