PATIENT REGISTRATION | INSURANCE

REVISED MARCH 10, 2021

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**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**⬜ Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK the BOX NEXT to YOUR PREFERRED METHOD of CONTACT (email, cell, home, work phone)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  
  
**Name**

LAST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST ­­­­\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_   
,

**Mailing Address**

STREET \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TOWN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE ZIP \_\_\_\_ \_\_\_  
  
 **⬜ Home Phone *(include area code)* ⬜ Work Phone (*include area code)* ⬜Cell Phone (*include area code)***

( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_ \_\_\_ \_\_\_\_\_

**Social Security No. Date of Birth Marital Status** (check one) **Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_|\_\_\_\_\_\_|\_\_\_\_\_\_\_ **⬜** SINGLE **⬜** MARRIED **⬜** SEPARATED **⬜** DIVORCED **⬜** WIDOWED

**Name of Emergency Contact Relationship Work Phone (*include area code)* Cell Phone (*include area code)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of person responsible for the account**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Dental Insurance Coverage**  P R I M A R Y | | |  | **Dental Insurance Coverage**  S E C O N D A R Y | | |
| NAME of Insurance Company | | |  | NAME of Insurance Company | | |
| ADDRESS |  | | ADDRESS |  | |
|  |  | |  |  | |
| PHONE | | | PHONE |  | |
| GROUP NO. | | SUBSCRIBER ID | GROUP NO. SU | | SUBSCRIBER ID |
| INSURED’S NAME | | | INSURED’S NAME | | |
| INSURED’S EMPLOYER | | | INSURED’S EMPLOYER | | |
| INSURED’S DATE of BIRTH | | | INSURED’S DATE of BIRTH | | |

**⬜**  **Check box if you DO NOT have dental insurance coverage**

**⬜**  **Medicare Acknowledgment** *|* **You must complete this section if you are 65 years or older**

You must sign here to acknowledge that you understand that Dr. Memoli DOES NOT accept *Medicare*(which DOES NOT pay for dental procedures)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** PATIENT SIGNATURE DATE