VICTORIA PLACE
DENTAL CENTER

Mohd Awwad D.D.S.
3144 Broadway SUITE #C1, Eureka, CA, 95501 USA
707-443-9374

Patient Registration

ID: | Chart ID:

First Name: | Last Name:

Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: | Last Name:

Address:

City: | State: | Zip: | Pager:

Home Phone: | Work Phone: | Ext: | Cellular:

Birth Date: | Soc. Sec: | Drivers Lic:

Responsible Party is ◯ Also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address:

City: | State: | Zip: | Pager:

Home Phone: | Work Phone: | Ext: | Cellular:

Sex: ◯ Male ◯ Female | Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: | Age: | Soc. Sec: | Drivers Lic:

E-mail: | ☐ I would like to receive correspondences via e-mail

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired | Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: | Pref. Dentist:

Employer ID: | Pref. Pharmacy:

Carrier ID: | Pref. Hyg.:

Primary Insurance Information

Name of Insured: | Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: | Insured Birth Date:

Employer:

Address:

City: | State: | Zip:

Insurance Company:

Address:

City: | State: | Zip:

Rem. Benefits: .00 | Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: | Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: | Insured Birth Date:

Employer:

Address:

City: | State: | Zip:

Insurance Company:

Address:

City: | State: | Zip:

Rem. Benefits: .00 | Rem. Deduct: .00

Patient's Signature:

Date:

Guardian's Signature:

Date: