PETER B. PRYOR Jr.
DMD

Patient Registration

Date:_____
Have you been seen by Dr. Pryor previously? ____ Yes ____ No
Please circle: Dr. Mr. Mrs. Miss Ms. Email address: _____

Name: _____

First Middle Maiden Last

Date of birth: __/___/___ Age: _____ Male____ Female ____ SS#: _____

Home Phone: (____)_____ Work: (____)_____ Cell: (___)_____

Home address:_____

Street City State Zip

Employer Name and City: _____

Name (Spouse):_____ Date of birth: ___/____/____ SS#:_____

Employer (Spouse): _____

Emergency contact Name: _____ Phone (___)_____

Relative or friend not living with you: _____Phone (___)_____

Whom may we thank for referring you to our practice? _____

Payment Information (Person Responsible for Payment of Treatment)

Name: _____ Date of Birth: __/__/__

Address: _____

Street City State Zip

Home Phone: (____)_____ Work: (___)_____ SS#:_____

I have dental benefits to help cover the cost of treatment: __Yes __ No
I plan to pay for treatment not covered by dental benefits using: Cash___ Check___ Credit ___

Dental Benefit Information

Primary Dental Benefit Company Name:_____

Address:_____

Street City State Zip

Benefit Holder Name and Employer: _____

Benefit Policy or Subscriber Number: _____ Group Number:_____

Secondary Dental Benefit Company Name:_____

Address:_____

Street City State Zip

Benefit Holder Name and Employer: _____

Benefit Policy or Subscriber Number: _____ Group Number:_____

Please provide your dental benefits card for photocopy.