



*Ash Kausshesh DDS FAGD MaCSD FDOCS*

*Implants, General, Cosmetic, TMJ  
IV Conscious Sedation  
Dental Care for Families, Geriatrics & Special needs*

**Serenity Dental Patient Registration**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Patient is  Policy Holder Preferred name \_\_\_\_\_  
 Responsible Party  
 Responsible party (if someone other than the patient) \_\_\_\_\_

**Patient Information**

Address \_\_\_\_\_ Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Pager \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cellular (\_\_\_\_) \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers License **State:** \_\_\_\_\_ **No:** \_\_\_\_\_  
**Sex:**  Male  Female **Marital Status**  Married  Single  Divorced  Separated  Widowed  
 E-mail \_\_\_\_\_@\_\_\_\_\_  
 Employment Status  Full Time  Part Time  Retired  
 Student Status  Full Time  Part Time   
 Who can we thank you for referring you to our practice? \_\_\_\_\_  
 What are your preferred pharmacies? \_\_\_\_\_  
 Who is your Emergency Contact person? \_\_\_\_\_ Emergency Contact Phone # (\_\_\_\_) \_\_\_\_\_  
 Are you available on short notice to come to our office for treatment?  Yes  No  
 If you are available on short notice, what days of the week and what times? \_\_\_\_\_

**Responsible Party (if someone other than the patient)**

Responsible party is also a policy holder for patient  Primary Insurance policy holder  Secondary Insurance Policy holder  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Address \_\_\_\_\_ Address 2: \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Pager \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cellular (\_\_\_\_) \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers License **State:** \_\_\_\_\_ **No:** \_\_\_\_\_

**Dental Insurance Information (Primary Insurance)**

Name of insured \_\_\_\_\_ Relationship to Insured  Self  Spouse  Child  Other  
 Insured Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Insured Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Employer Information** **Primary Insurance Information**  
 Employer \_\_\_\_\_ Insurance Co \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Dental Insurance Information (Secondary Insurance)**

Name of insured \_\_\_\_\_ Relationship to Insured  Self  Spouse  Child  Other  
 Insured Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Insured Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Employer Information** **Primary Insurance Information**  
 Employer \_\_\_\_\_ Insurance Co \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_