Ash Kaushesh DDS, MAGD, MaCSD, DDOCS, DABOI/ID

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 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

Employer _____

Address _____

Address 2 _____

City, State,Zip _____

Primary Insurance Information

Insurance Co _____

Address _____

Address 2 _____

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

Employer _____

Address _____

Address 2 _____

City, State,Zip _____

Primary Insurance Information

Insurance Co _____

Address _____

Address 2 _____

City, State,Zip _____