

**Drum Hill Dental Care, P.C.**

Dr. Richard C. Karp, D.M.D.  
General and Family Dentistry

117 Drum Hill Rd., Chelmsford, MA 01824  
Tel: (978) 454-5656

Patient Number \_\_\_\_\_

**PATIENT REGISTRATION**

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_  
Last First Initial Date of Birth (mm/dd/yy)

Male  Female Age: \_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed

Home Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip Code

Do you have a personal physician?

Yes  No

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**DENTAL INSURANCE**

**Primary Insurance**

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Group or Plan ID: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation to patient:

Self  Spouse  Parent

Insured's Social Security Number: \_\_\_\_\_

Birth date: \_\_\_\_\_

Employer: \_\_\_\_\_

**Secondary Insurance**

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Group or Plan ID: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation to patient:

Self  Spouse  Parent

Insured's Social Security Number: \_\_\_\_\_

Birth date: \_\_\_\_\_

Employer: \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance company.

PATIENT or GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_