R|S
ROBERT SAVAGE, D.D.S.
REDWOOD CITY FAMILY DENTISTRY
650.367.8833

REGISTRATION FORM

Thank you for expressing your confidence in choosing our practice! We look forward to assisting you with your dental needs. Please fill out this form in **INK ONLY**. *If you have any questions regarding this form do not hesitate to ask for assistance. We will be happy to help.*

Patient Name: _____ Date of Birth: _____
Last First

SS#: _____ Email Address: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Spouse/Guardian Name: _____ **Text Message 1 day before Appt? ☐ YES ☐ NO**

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

What is the best way to contact you? ☐ Home ☐ Cell ☐ Work ☐ Email

Occupation: _____ Employer Name: _____

Address: _____ City/State/Zip: _____

Who may we thank for referring you?_____

Previous dentist: _____ City: _____ Phone: _____

Reason for visit: _____

RESPONSIBLE PARTY

Name of person responsible for account: _____ Relationship: _____

Date of Birth: _____ Age: _____ SS#: _____ Phone: _____

Address: _____ City/State/Zip: _____

Employer Name: _____ Work Phone: _____

PLEASE LIST EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship:_____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Relationship: _____

Date of Birth: _____ SS#: _____ ID #: _____

Insurance Company: _____

Ins. Co. Address: _____ City/State/Zip: _____

Ins. Co. Phone: _____ Group #: _____

Employer Name: _____ Work Phone: _____

Do you have Secondary Dental Insurance? ☐ YES ☐ NO

Subscriber's Name: _____ Relationship: _____

Date of Birth: _____ SS#: _____ ID #: _____

Insurance Company: _____

Ins. Co. Address: _____ City/State/Zip: _____

Ins. Co. Phone: _____ Group #: _____

Employer Name: _____ Work Phone: _____

I hereby authorize payment directly to Redwood City Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health care professionals as is beneficial for payment or dental care.

_____ _____
Signature of Patient or Parent/Guardian Date