John M Schiefelbein, DMD, PLLC
246 Division St/PO Box 787
Leavenworth, WA 98826
(509) 548-5841

Patient Registration Form

Patient Name: _____ Last First MI			Preferred Name: _____	
Gender:	Birthdate:	Age:	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed	
Home Ph:	Cell Ph:			
Address:	City:	State:	Zip:	
Mailing Address (if different)	City:	State:	Zip:	
Email:		❑ may we use email for important information		
How did you hear about us?	❑ Referring Office ❑ Internet ❑ Friend ❑ Family			

Who is Responsible for Payment? ❑ **same as above**

Name: _____ Last First	Relationship to Patient: _____		
Birthdate:	Email address:		
Address:	City:	State:	Zip:
Home Ph:	Cell:	Work:	

Primary Dental Insurance		**Secondary Dental Insurance**	
Subscriber Name:		Subscriber Name:	
Subscriber I.D. #:	DOB:	Subscriber I.D. #:	DOB:
Employer:		Employer:	
Insurance Co:		Insurance Co.:	
Group Name:	Group ID#:	Group Name:	Group ID#:
Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other		Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other	

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name:	Home Ph. #
Relationship to Patient:	Other Ph. #:

Patient (Guardian) Signature: _____ **Date:** _____