J. Peter St.Clair, DMD
FAMILY & ESTHETIC DENTISTRY

151 Central Street | Rowley, MA 01969 | 978.948.2030
www.stclairdmd.com

PATIENT REGISTRATION FORM

Name: _____ Preferred Name: _____ Birthdate: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed/er

Address: _____ City: _____ ST: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____ City: _____ Occupation: _____

Name of Spouse / Parent / Guardian: _____ Birthdate: _____
(circle one)

Address (if different from above): _____ City: ____ ST: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ City: _____ Occupation: _____

In case of emergency, whom shall we notify other than spouse?

Name: _____ Relationship: _____Phone:_____

DENTAL INSURANCE INFORMATION

Subscriber: _____
Subscriber ID #: _____
Subscriber DOB: _____
Ins. Co. Name: _____
Ins. Co. Address: _____
Ins. Co. City, ST, Zip: _____
Ins. Co. Phone: _____
Group/Policy #:_____

☐ **Do you have secondary dental insurance?**

SECONDARY DENTAL INSURANCE INFO

Subscriber: _____
Subscriber ID #: _____
Subscriber DOB: _____
Ins. Co. Name: _____
Ins. Co. Address: _____
Ins. Co. City, ST, Zip: _____
Ins. Co. Phone: _____
Group/Policy #: _____

MEDICAL INSURANCE INFORMATION (if required for treatment.)

Subscriber: _____
Subscriber ID #: _____
Subscriber DOB: _____
Ins. Co. Name: _____
Ins. Co. Address: _____
Ins. Co. City, ST, Zip: _____
Ins. Co. Phone: _____
Group/Policy #:_____