Phone: 317-852-9787
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Brownsburg Dental Professionals PC
1040 Patrick Place STE B
Brownsburg IN 46112

www.brownsburgdental.com
Email: Info@brownsburgdental.com

Please Print clearly, thank you.

Patient Registration

Date: __________

First Name:__________________________ Last Name:____________________ Middle Init: _____
Address:____ City, State, Zip:____________________
Home Phone: ___________________ Cell:_____________________ Work:____________________
Email:__________________________________Birthdate:______ Age:____ SSN:_____________
Sex: M ___ F___ Marital Status:___Married ___Single ___Divorced ___Separated ___ Widowed
Student Status: __ Full Time __ Part Time Name of School: ___________________________
Name of Employer: ______________________________________ City/State: _________________
Preferred Pharmacy and Location:____
How did you find our office?____

Responsible Party (if someone other than patient) SSN:______________________

First Name:_______________________ Last Name:______________________ Middle Initial:____
Address:______________________________________City, State, Zip:_________________________
Birth Date:______________Home:_____________Cell:________________Work:______________
Responsible Party is: ___the Ins. policy holder ___ Primary Ins. Holder ___ Secondary Ins. Holder

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Insurance Information – please provide card if possible

Name of Policy Holder:_________________________ Birthdate:__________ SSN:_____________
Relationship to Patient: __Self __ Spouse __Child __Other Policy ID #:____________________
Policy Holder's Employer:________________________________ City/State:__________________
Name of Insurance Company:_________________________________ Phone:_________________
Address:____ City, State:_________________________

Secondary Insurance Information – please provide card if possible

Name of Policy Holder:_____________________________ Birthdate:__________ SSN:__________
Relationship to Patient: __Self __Spouse __Child __Other Policy ID #:____________________
Policy Holder's Employer:______________________________ City/State:_____________________
Name of Insurance Company:_________________________________ Phone:_________________
Address:____ City, State:___________________________

The above information is accurate to the best of my knowledge. I authorize Brownsburg Dental Professionals to release any required information to process my insurance claims. I further understand that I am responsible for all fees incurred associated with services provided.

_______________________________ Signature

_______________________ Date

6/2017