Linda G. Goltz, D.D.S.
Abby L. King, D.D.S.

Generations
FAMILY DENTISTRY

office@GenerationsDentistry.com
989-686-7174

Patient Registration and Insurance

Patient name ______________________________ Birth Date ______________

SS # ______________ Home phone and/or cell ______________________________

Preferred number to confirm appointments ______________ Email ______________________

Address ______________________ City ____________ State ________ Zip ________

Employer ______________________ Work phone ______________ Ext. ________

Referred by ______________________

Marital status: ☐ S ☐ M ☐ W ☐ D

Spouse ______________________ Employer ______________________

SS # ______________________ Phone ______________________

Dental Insurance

Primary Insurance

Insured's name ______________________

Insured's birth date ______________________

SS # ____________ Group # ____________

Insurance carrier ______________________

Employer ______________________

Secondary Insurance

Insured's name ______________________

Insured's birth date ______________________

SS # ____________ Group # ____________

Insurance carrier ______________________

Employer ______________________

If Patient is a Minor – Please Complete Below

Parents' marital status: ☐ Married ☐ Divorced ☐ Separated

Person financially responsible: ☐ Father ☐ Mother ☐ Both

Father's name ______________________________ Birth date ______________

Address (if different than child's) ______________ City ____________ State ________ Zip ________

Employer ______________________________ Work phone ______________

SS # ______________ Cell phone ______________ Email ______________

Mother's name ______________________________ Birth date ______________

Address (if different than child's) ______________ City ____________ State ________ Zip ________

Employer ______________________________ Work phone ______________

SS # ______________ Cell phone ______________ Email ______________