Thomas P.A. Carchidi, D.M.D.
FAMILY DENTISTRY

167 Village Street
Medway, Massachusetts 02053
Telephone: (508) 533-6400
Fax: (508) 533-6400
www.MedwayVillageDentist.com

PATIENT REGISTRATION FORM

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Patient's Name: _____ **SSN:** _____
(Last, First, Middle)

Date of Birth: _____ **Age:** _____ **Sex:** ☐Male ☐Female **Ht:** ____ ' ____ " **Wt:** _____ lbs

Patient Address: _____
(City, State, Zip Code)

Home Phone: (____) ____-____ ☐
Cell Phone: (____) ____-____ ☐
Work Phone: (____) ____-____ ☐

Please place a check next to the phone number you prefer for confirming appointments.

Email Address: _____

Occupation: _____ **Employer:** _____

If student, name of school: _____

School Address: _____
(City, State, Zip Code)

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed (Please check appropriate box)

Emergency Contact: _____ **Phone:** _____

Spouse, Parent, or Guardian Information

Relation to Patient: ☐Spouse ☐Parent/Guardian ☐Other _____

Name: _____ **SSN:** _____
(Last, First, Middle) (For Billing)

Address: _____
(City, State, Zip Code)

Employer: _____ **Work Phone:** _____ **Cell:** _____

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Dental Insurance Information

Name of Insured: _____ **Relationship:** _____

Dental Insurance: _____ **SSN/Sub-ID:** _____
(Required for filing Insurance)

Name of Employer: _____ **Group #:** _____

Do you have additional Dental Insurance? ☐Yes ☐No If **YES**, complete the following:

Secondary Dental Insurance Information

Name of Insured: _____ **Relationship:** _____

Dental Insurance: _____ **SSN/Sub-ID:** _____
(Required for filing Insurance)

Name of Employer: _____ **Group #:** _____

Agreement and Consent

I agree to assume full financial responsibility for all the dental treatment rendered. I consent to the dental procedures and anesthetics that are considered necessary for all proposed treatment that will be fully discussed and understood prior to proceeding.

_____	_____	_____
(Signature of Patient, Parent or Guardian)	(Signature of Dentist/Witness)	(Date)

Who can we thank for referring you? _____