PETER R. SCELFO, DDS
FAES, FRSH

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: _____

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work? ☐ Yes ☐ No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	

Medical Alert Sticker

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name/ Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other	☐ UCR ☐ Schedule of Payments ☐ Other
Coinsurance	Company _____ % Patient _____ %	Company _____ % Patient _____ %
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ _____ ☐ Lifetime $ _____	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ _____ ☐ Lifetime $ _____
Plan Covers Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other		

If credit card payment is accepted: Name of Card _____

Card # _____ Expiration Date _____