1) PLEASE FILL OUT
2) PRINT
3) BRING WITH YOU TO YOUR VISIT

Dr. Gabriela Bozzuti, DDS - Dental Wellness at Weston
(954) 706-6440

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle: ____
Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____
Address: _____ Address 2: _____
City, State, Zip: _____ Cell: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Birth Date: _____ Soc Sec: _____ Drivers Lic: _____
Responsible Party is also ☐ Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City, State, Zip: _____ Cell: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed
Birth Date: _____ Age: ____ Soc Sec: _____ Drivers Lic: _____
E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired
Student Status: ◯ Full Time ◯ Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hyg: _____

Section 3

Emergency Contact: _____
Emergency Contact #: _____
Referred By: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other
Insured Soc Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other
Insured Soc Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____