Kelley L. Borders D.M.D

Patient registration

Information will be held in the strictest of confidence.

Patient Name	**Date**
Address	**S.S.**
City, State, Zip	**D.O.B.** **Age**
Male __ Female __ Single __ Married __ Minor __ Widow __	**Home Phone**
Employer/School	**Work Phone**
Address	**Cell Phone**
City, State, Zip	**E-mail**
Occupation	**Notes:**
Referred by:	

Person responsible for account: Relation:

Your Spouse	**Dental Insurance**
Name	**Policy Holder**
D.O.B.	**Relation to Patient**
S.S.	**Insurance Co.**
Employer	**Group#** **ID#**
Work Phone	**Phone**
Emergency Contact	**Secondary Insurance**
Name	**Policy Holder**
Relationship	**Insurance Co.**
Phone 1:	**Group#** **ID#**
Phone 2:	**Phone**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Kelley L. Borders D.M.D. or insurance company to release any information required to process my claims.

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Patient/Guardian signature Date