AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA

Patient Registration
Clinic for Anaplastology

PATIENT REGISTRATION DATE:

Patient's Name: _____ Birthdate: _____

Street Address: _____ Home #: _____

City / State / Zip: _____ CELL #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Gender: M ☐ F ☐ Ethnicity: _____

Email: _____ Occupation: _____

Employer: _____

Emergency Contact: _____ *Phone number (C/H/W):* _____

Relationship: _____

INSURANCE COVERAGE: Please copy front and back of all insurance cards

Insured Name: _____ Birthdate: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Gender: M ☐ F ☐ Email: _____

PRIMARY Insurance Payer: _____ **Plan/Group #:** _____

Insured ID: _____ Effective date: _____

SECONDARY Insurance Payer: _____ **Plan/Group #:** _____

Insured Name: _____ Birthdate: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Gender: M ☐ F ☐ Email: _____

Insured ID: _____ Effective date: _____

Workman's Compensation ☐ Yes ☐ No Place of Employment: _____

PROSTHETIC AND MEDICAL HISTORY:

The need for a prosthesis is related to: ☐ Birth malformation ☐ Illness / disease ☐ Accident: (Date) _____

Type of prosthesis needed: _____

Please give last date and type of surgery: _____

AN ☐ Yes ☐ No If yes, please explain: _____

Are you diabetic? ☐ Yes ☐ No

Have you undergone Radiation Therapy? ☐ Yes ☐ No If yes, date of last treatment _____

Have you undergone Chemo Therapy? ☐ Yes ☐ No If yes, date of last treatment _____

REFERRING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION:

Name: _____ Phone #: _____

Clinic/Department: _____

City/State/Zip: _____

PATIENT'S SIGNATURE (or parent if patient is a minor) **DATE:**

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