Christopher T King, DDS, PC

4605 HAYGOOD ROAD | VIRGINIA BCH VA, 23455 | (757) 464-6228

Patient Registration

PATIENT INFORMATION: Date_____

Last Name:_____First Name:_____MI:____

Prefers to be called by:_____

Address:_____

City:_____State:_____Zip:_____

Primary Phone #_____(home/cell) Secondary # _____(home/cell)

Email Address:_____

Birthdate:_____ Male / Female (circle one) Social Security#_____

Married / Single (circle one) Spouse's Name:_____

Emergency Contact Name:_____Phone #_____

IF THIS APPOINTMENT IS FOR YOUR CHILD/DEPENDANT PLEASE PROVIDE GUARDIAN INFORMATION:

Last Name:_____First Name:_____MI:____

Relationship to Patient:_____Birthdate:_____Social Security #: _____

Address:_____

City:_____State:_____Zip:_____

Primary Phone #_____(home/cell) Secondary # _____(home/cell)

Email Address:_____

DENTAL INSURANCE (PRIMARY CARRIER)	DENTAL INSURANCE (SECONDARY CARRIER)
Insurance Company	Insurance Company
Group No.	Group No.
Employer Name	Employer Name
Insured's Name	Insured's Name
Date of Birth	Date of Birth
Relationship to Patient	Relationship to Patient
Insured's ID #	Insured's ID #
Insured's SSN	Insured's SSN

You were referred to us by:_____