# OMAHA LASER DENTISTRY

Anthony R. Bolamperti, D.D.S.

## PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is: ☐ Responsible Party ☐ Policy Holder

### RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Driver's License #: _____

◯ Responsible Party is Policy Holder for Patient ◯ Primary Policy Holder ◯ Secondary Policy Holder

### PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Social Security #: _____ Driver's License #: _____

Email: _____ ☐ I would like to receive email correspondences

Employment Status: ◯ Part Time ◯ Full Time ◯ Self Employed ◯ Retired ◯ Unemployed

Student Status: ◯ Part Time ◯ Full Time

Referred By: _____

### PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, ZIP: _____ City, State, ZIP: _____

Do You Carry Secondary Insurance? ◯ Yes ◯ No