



COSMETIC DENTISTRY
OF BATON ROUGE

Mark A. Ventress, DDS

GENERAL DENTISTRY

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632 Shadows Lane, Suite B
Baton Rouge, LA

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE				1
LAST NAME		FIRST	M.I.	
PREFERRED NAME:				
ADDRESS				
CITY				
HOME PHONE NO.	CELL PH #	WORK PHONE #		
EMAIL ADDRESS				
PREFERRED CONTACT (PICK ONE) <input type="checkbox"/> HM <input type="checkbox"/> CELL <input type="checkbox"/> WK				
<input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SSN.	DL#			
OCCUPATION				
EMPLOYER				
EMPLOYER ADDRESS				
CITY				
EMPLR PHONE NO.				
SPOUSE NAME				
SPOUSE DAYTIME PHONE				

DENTAL INSURANCE		2
PRIMARY CARRIER		
EMPLOYER'S NAME		
INSURANCE COMPANY NAME		
GROUP NO.		
CLAIM ADDRESS		
INSURED'S NAME	RELATIONSHIP	
INSURED DATE OF BIRTH		
INSURED'S SOCIAL SECURITY NO.		
INSURED MEMBER ID NO.		
SECONDARY CARRIER		
INSURED'S NAME	RELATIONSHIP	
INSURANCE COMPANY		
GROUP NO.		
CLAIM ADDRESS		
INSURED DATE OF BIRTH		
INSURED SOCIAL SECURITY NO.		
INSURED MEMBER ID NO		

ACCOUNT INFORMATION	4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY STATE ZIP	
PHONE NUMBER	
<p><i>If parents are divorced, the parent that brings the child for treatment is responsible for account.</i></p>	

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
YOU WERE REFERRED TO US BY:	
PERSON TO CONTACT FOR EMERGENCY:	
PHONE NUMBER	RELATIONSHIP:
CLOSEST RELATIVE NOT LIVING WITH YOU:	
PHONE NUMBER	RELATIONSHIP:

PLEASE TURN OVER AND SIGN