



Steven Tsuchida, DDS

Welcome Patient Registration

PATIENT NAME (Last, First, Middle Initial)	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	MARITAL STATUS
HOME PHONE CELL PHONE	GENDER Male Female
PREFER () Morning Appointments Or () Afternoon Appointments	RELATIONSHIP TO INSURED Self Spouse Child
EMPLOYER	WORK PHONE
OCCUPATION	E-MAIL ADDRESS

Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Referred to this office by:

NAME	PHONE
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Insurance Information

Primary Coverage

Secondary Coverage

SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION
SIGNATURE	DATE

Verification of Benefits

For office use only Calendar Year	For office use only Calendar Year
Yearly Plan Maximum \$ Deductible \$	Yearly Plan Maximum \$ Deductible \$
Class 1 % Class 2 % Class 3 %	Class 1 % Class 2 % Class 3 %
Preauth/Films Necessary Yes No Coverage for: FMX BW	Preauth/Films Necessary Yes No Coverage for: FMX BW
PANO	PANO
ProDhv Sealants	Prophy Sealants
Electronic Pay Yes No Payor ID	Electronic Pay Yes No Payor ID
Mail Claim to	Mail Claim to