



HAZELTON FAMILY DENTISTRY

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www.hazeltonfamilydentistry.com

PATIENT REGISTRATION

ID: _____ CHART ID: _____

First Name _____ Last Name _____ Middle Initial _____

Patient Is: Policy Holder Responsible Party Preferred Name _____

Responsible Party (if someone other than patient)

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ S.S.# _____ Drivers Lic. _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

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

Birth Date _____ Age _____ S.S.# _____ Drivers Lic. _____

Email _____ I would like to receive correspondences via e-mail.

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID _____ Pref. Dentist _____

Employer ID _____ Pref. Pharmacy _____

Carrier ID _____ Pref. Hyg _____

Section 2

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Primary Insurance Information

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

Insured S.S.# _____ Insured Birth Date _____

Employer _____

Address _____

City, State, Zip _____

Rem. Benefits _____ .00 Rem. Deduct _____ .00

Ins. Company _____

Address _____

City, State, Zip _____

Secondary Insurance Information

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

Insured S.S.# _____ Insured Birth Date _____

Employer _____

Address _____

City, State, Zip _____

Rem. Benefits _____ .00 Rem. Deduct _____ .00

Ins. Company _____

Address _____

City, State, Zip _____