Stummer Dental and Sleep Medicine Group

Patient Registration

Patient Information

First Name_____ **Middle Initial**_____ **Last Name**_____

Address_____**City**_____**State**_____ **Zip**_____

Home Phone _____**Cell Phone**_____ **Work Phone**_____

Date of Birth_____**Social Security Number**_____ **E-mail Address**_____

Please tell us how you heard about us._____

If someone other than the patient is the responsible party, please fill out the next section.

Responsible Party

First Name_____ **Middle Initial**_____ **Last Name**_____

Address_____**City**_____**State**_____ **Zip**_____

Home Phone _____**Cell Phone**_____ **Work Phone**_____

Date of Birth_____**Social Security Number**_____ **E-mail Address**_____

Primary Insurance Information

Name of Insured_____ **Relationship to Insured**_____

Date of Birth of Insured_____**Social Security Number**_____

Self Insured or through employer_____**Name of Employer**_____

Please allow us to copy your insurance card or fill in the following regarding your Insurance:

Full Name of Insurance Company_____**Customer Service Phone Number**_____

Address of Insurance Company_____ **Customer Service Phone Number**_____

Group Number_____ **ID Number**_____

Secondary Insurance Information

Name of Insured_____ **Relationship to Insured**_____

Date of Birth of Insured_____**Social Security Number**_____

Self Insured or through employer_____**Name of Employer**_____

Please allow us to copy your insurance card or fill in the following regarding your Insurance:

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