



COLUMBUS GROVE FAMILY DENTISTRY

QUALITY CARE FOR ALL AGES

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419-659-6000 Main - 419-659-6004 Fax
www.myfamilydentist.biz

DATE: _____

PATIENT REGISTRATION

First Name: _____ Last: _____ Middle: _____

Nick/Preferred Name (If Any): _____ Address (St/PO): _____

City: _____ State/Zip Code: _____ Email Address: _____

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

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

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

Employment Status: ___ NA ___ Full Time ___ Part Time ___ Retired

Responsible Party Information (If Someone Other than Patient)

First Name: _____ Last: _____ Middle: _____

Nick/Preferred Name (If Any): _____ Address (St/PO): _____

City: _____ State/Zip Code: _____ Email Address: _____

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

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

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

Employment Status: ___ NA ___ Full Time ___ Part Time ___ Retired

Primary DENTAL INSURANCE Information:

Name of Insured: _____ Relationship to Patient: ___ Self ___ Spouse ___ Parent

Insured Social Security#: _____ Insured Date of Birth: _____

Employer: _____ Ins Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Group #: _____ ID # _____

Secondary DENTAL INSURANCE Information:

Name of Insured: _____ Relationship to Patient: ___ Self ___ Spouse ___ Parent

Insured Social Security#: _____ Insured Date of Birth: _____

Employer: _____ Ins Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Group #: _____ ID # _____

In Case of Emergency, Contact: (Please List an Individual who does not Live in Your Household):

Name/Relationship: _____ Home Phone: _____ Cell Phone: _____

Whom May We Thank for Referring You?: _____