STEVEN P. WALKER, D.D.S.
207 S. 4th Street
Chesterton, IN 46304-2345
(219) 926-4321

PATIENT REGISTRATION

First Name: Last Name: Middle Initial:________

Patient is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ____________________

Referred by: ______________________________

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:_______

Address 1: Address 2: ______________________________

City, State, Zip: ____

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc. Sec. : Driver's Lic: ____________________

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

Patient Information

Address 1: Address 2:

City: State / Zip:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Soc. Sec. : Driver's Lic:

Best Place to call: ○ Home ○ Work ○ Cell phone Best time to call: ○ morning ○ evening

"ection 2 Section 3

Occupation:

Employment Status: ○ Full Time ○ Part-Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Primary Care Physician:

Phone Number:

Preferred Hygienist:

Preferred Pharmacy:

Emergency Contact:

Relationship:

Phone Number:

Primary Dental Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins Company:

Address: Address:

Address 2: Address 2:

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

Employer ID: Insured ID # :

Secondary Dental Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins Company:

Address: Address:

Address 2: Address 2:

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

Employer ID: Insured ID # :