Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

PATIENT REGISTRATION

Patient Information:

First Name: ____________________ Middle Initial:_______
Last Name: ____________________
Preferred Name:____________________
Address: ____________________
City, ____________________ State, ______________ Zip: ______________
Address 2: ____________________
City, ____________________ State, ______________ Zip: ______________
Home Phone: (___)_____________ Work Phone: (___)_____________Cell Phone: (___)____________
□ I agree to receive text messages from the dental office
Sex: ○ Female ○ Male
Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth date: ______________ Social Security #: __________________ Drivers Lic#: _________________
E-mail: ____________________
□ I agree to receive email correspondences from the dental office

Patient's or Parent's/Guardian Employer: ____________________
Work Phone:(___)____________
IF College Student Name of School: ____________________
Student Status: ○ Full Time ○ Part Time

Name of Person to contact in an emergency or if unable to reach you:

____

Phone: (___)____________________

Whom may we thank for referring you? ____________________

Responsible Party: (if someone other than the patient)

First Name: ____________________ Middle Initial: ______
Last Name: ____________________
Address: ____________________
Address 2: ____________________
Home Phone: (___)____________ Work Phone: (___)______________ Cell Phone:(___)______________
Birth date: _____________ Social Security #: ___________________ Drivers Lic#: _________________

X____________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

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○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

DENTAL INSURANCE INFORMATION

Primary Insurance Information:
Name of Insured: ____
Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other
Employer ID: ____________________Carrier ID:________________________
Insured Social Security #: _______________Insured Birth date: ________________
Employer: ______________________Insurance Company:_________________
Address: ____
City,___________________________ State,________ Zip:_____________
Address 2: ____
City,_________________________ State,___________ Zip: ____________

Secondary Insurance Information:
Name of Insured: ____
Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other
Employer ID: ______________________ Carrier ID:__________________
Insured Social Security #: ________________ Insured Birth date: _______________
Employer: ____________________ Insurance Company: __________________
Address: ____
City,___________________________ State,________ Zip: _____________
Address 2: ____
City, __________________________ State, _________ Zip:_____________

- **Attach a copy of the front and back of your Dental insurance card and ID or Driver's license**

X____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE