Carnaggio & Piper DMD, MS, PA
275 N. Main St. Unit B
Troutman, NC 28166
704-980-4301

REGISTRATION FORM **Date___________________**

Section 1 **Patient Information**

Name: ____ Preferred Name: _____________________

Address: ___________________________________City:____________State:_______Zip____________

Home Phone: (_____)__________ Work Phone: (____) ___________ Cell Phone: (_____)_______________

Date of Birth: ____________ Social Security Number:_____________________ ☐ You can contact me at work

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School: _______________________ City/State: ________________________ ☐ FT ☐ PT

Spouse or Parent's Name: _________________________ Employer: _____________Work Phone:__________

Person to contact in case of emergency: ______________________________ Phone: ____________________

Whom may we thank for referring you? ____

Email Address: _________________________________ Would you like to receive our e-notifications? ☐ Yes ☐ No

Section 2 **Responsible Party**

Relationship to Patient: ☐ Self (Skip to Section 3) ☐ Spouse ☐ Parent ☐ Other _____________

Name:____

Address: ____

City: ___________________________ State:________ Zip:__________ Phone: (____)_________________

Employer: ____________________ Work Phone: (____)______________ SSN#: _______________________

Section 3 **Dental Insurance Information**

Name of Insured: _________________________ DOB: ___________ Relationship to Patient: _____________

SSN#:____________________ Name of Employer: ___________________ Work Phone: (____)____________

Address of Employer: ____________________________ City:____________State:_______Zip:_________

Insurance Company: _______________________ Grp #: _________________ ID#: ____________________

Ins Co Address: ______________________________________ Ins Co. Phone:________________________