BELLEVUE · COMMONS
ENDODONTICS

Dean Burnett, DDS, MS, PS
425-641-3300

Patient Registration Form

Patient Information

First Name_____ Last Name _____Middle Initial _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ _____

Cell Phone_____ Email _____

How may we contact you for appointment reminders and other communications?

❑ Cell Phone ❑ Email ❑ Home Phone ❑ Work Phone

How were you referred to our office?_____

Birth Date _____ SSN _____ Driver's Lic. _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed

Responsible Party (if other than patient)

First Name_____ Last Name _____Middle Initial _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Birth Date _____ SSN _____ Driver's Lic. _____

❑ Responsible Party is also the policy holder ❑ Primary insurance holder ❑ Secondary insurance holder

Insurance Information

Name of Insured _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured ID _____ Insured Birth Date _____

Employer_____

Employer City, State, Zip _____

Insurance Company _____ Insurance Phone Number_____

Insurance City, State, Zip _____