M. Scott Peele, DDS, PA ~ 1087 Hendersonville Rd.~ Asheville, N.C. 28803 ~ 828-274-4747

PATIENT REGISTRATION

First Name: _____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Address: _____ City, State, Zip: _____

Home Phone : ( )_____ Work Phone : ( ) _____ Cell Phone : ( ) _____

Birth Date : ___/_____/_____ Soc Sec No : _____ Drivers License No. _____ State_____

Sex : ___M ____F Marital Status : ___ Married ___Single ____Divorced ___Separated ___Widowed

Email Address : _____ Student: ___ Full Time __ Part Time Name of School _____

Employer:_____ **Address**: _____ **Phone No.**( ) _____

RESPONSIBLE PARTY (if other than patient) First Name _____ Last Name_____

Address: _____City, State, Zip : _____ Phone No. ( ) _____

INSURANCE INFO- PLEASE PRESENT YOUR CARD WITH THIS FORM

Name of Insured: _____

Your relationship to Insured :___Self _____Spouse _____Child ____ Other

Insured Soc Sec No. : _____ **Insured** Birth Date : _____

Insured Employer: _____

Insurance Company Name : _____

Address : _____

_____

Phone No : _____ Group No. _____ Member ID No. _____

Deductible Amount : _____ Maximum Yearly Benefit : _____

Preferred Pharmacy : _____ Phone No. ( ) _____

Emergency Contact Person : _____ Phone No. ( ) _____

PLEASE FILL OUT THE BACK OF THIS FORM ALSO.