WELCOME TO THE OFFICE OF DR. ROBERT C. KUEPPER, D.D.S.

Please take a moment to fill out our patient registration form

Date:_____ SS#_____

Sex: M F Date of Birth: _____ Marital Status:_____

Patient's Name:_____

Mailing Address: _____

Residential Address:_____

Home Phone: _____ Cell Phone:_____ Business Phone:_____

Patient Employer & Address_____

Name of Spouse & Address (if different) _____

Name & Address of Parent, D.P.O.A or Legal Guardian _____

** Note: Any patient who is a minor, who has been appointed a D.P.O.A or legal guardian must be accompanied by the parent, DPOA or legal guardian during their time of evaluation and/or treatment in this office**

Name of person responsible for this bill (after insurance): _____

Relationship_____ Address:_____

Home Phone:_____ Cell phone: _____ Business:_____

Nearest Friend or Relative:_____ Phone:_____

Have you or any of your family members ever been a patient at our office before?:_____

Who is your regular dentist? _____

Who is your medical doctor?_____

Who referred you to our practice?_____

Disclosure Information:
If you would like us to be able to discuss and disclose your medical and dental care and/or billing account information with anyone other than yourself, please list below:

_____

Name Relationship Telephone #

_____

Name Relationship Telephone #

Insurance Information
Is there a divorce decree or other special situation that dictates how insurance should be billed? Yes___ No___
Per divorce decree please list the order that insurance should be billed_____