Beverly Hills Dental
Dr. Raphael Lewis D.D.S.

Patient Registration

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

Sex: Male / Female Marital Status: Married / Single / Divorced / Separated / Widowed

Preferred Pharmacy: _____ Pharmacy City: _____

Email: _____

Would you like to receive email correspondences from our office? YES / NO

How did you hear about our office? (Please check one)

○ Newspaper ○ Google ○ Office Website ○ Flyer in Mail

○ Patient Referral - Patient Name: _____

○ Other (Please Explain):_____

Primary Insurance: (If applicable)

Name of Policy Holder: _____

Name of Insured: _____ Relationship to policy holder: Self/Spouse/Child/Other

Insurance Company: _____

Employer _____ OR Retired Plan / Individual Plan

Social Security/Member ID #: _____ Group Number: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature

Name of Parent/Guardian: _____
(Please Print)

Signature of parent/Guardian: _____ Date: _____

Relationship to Patient: _____

***PLEASE NOTE: We do not accept secondary insurance as a form of payment. You are responsible for the remaining balance from your primary insurance at time of service. As a courtesy, we will submit to your secondary insurance for you.**