Axcel Dental
Dr. Purna Shah, DMD
3368 S Linden Rd, Flint, MI, 48507
(810) 339 0471
www.axceldental.com

## Patient Registration Information – Please Print using black or blue ink

| Title | Patient's Last Name | First Name | Middle | Preferred | Gender |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth | Social Security No. | Marital Status | Email Address |
|---|---|---|---|
| | | | |

| Home Address | Apt or Box No. | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

Home Phone Number _____ Daytime Phone Number _____ Cell Phone Number _____

Preferred Method of Contact:
Text me at _____ Send me an email at _____@_____ Call me at _____

Emergency Contact – Name Relation Daytime Phone No. Address (Street, City, State, Zip)

Race/Ethnicity (optional)
Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Hispanic / Latin / Spanish Yes ☐ No ☐

## Guardian Information

| Title | Last Name | First Name | Middle | Relation | Gender |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth | Social Security No. | Marital Status | | |
|---|---|---|---|---|
| | | | | |

| Home Address | Apt or Box No. | City | State | Zip Code | Email Address |
|---|---|---|---|---|---|
| | | | | | |

Home Phone Number Daytime Phone Number Cell Phone Number Preferred Contact Number

## Patient's Primary Dental Insurance Information

| Subscriber's Name | Subscriber's ID | Subscriber's DOB | Insurance Co. | Group No. |
|---|---|---|---|---|
| | | | | |

| Employer | Address of Employer | Subscriber's Relationship to Patient |
|---|---|---|
| | | |

## Patient's Secondary Dental Insurance Information

| Subscriber's Name | Subscriber's ID | Subscriber's DOB | Insurance Co. | Group No. |
|---|---|---|---|---|
| | | | | |

| Employer | Address of Employer | Subscriber's Relationship to Patient |
|---|---|---|
| | | |