Chelsea Baraff, DMD
1470 SW Knoll Ave Ste 101
Bend, OR 97702

Patient Registration

Today's Date: _____ Patient Name: _____
DOB: _____ Nickname: _____ Gender: M/F/Other
Address: _____
Phone Number: _____ (Home/Work/Cell) _____ (Home/Work/Cell)
Email: _____ Pharmacy: _____
Can the cell number receive texts? Yes / No Preferred Contact: Phone / Text / Email

Emergency Contact:
Name: _____ Relationship: _____ Phone: _____

How did you hear about us? _____

Primary Insurance Information

Insurance Company Name: _____
Employer (if applicable): _____
Subscriber Name: _____ Subscriber DOB:_____
Subscriber SSN: _____ Relationship: _____
Identification Number: _____ Group Number: _____

Secondary Insurance Information

Insurance Company Name: _____
Employer (if applicable): _____
Subscriber Name: _____ Subscriber DOB:_____
Subscriber SSN: _____ Relationship: _____
Identification Number: _____ Group Number: _____