



**AVALON DENTAL**  
Bradley P. Dilling, DMD

**Patient Registration**

13981 McGregor Blvd. STE 203  
Fort Myers, Florida 33919  
Phone: (239) 454-1150  
[www.fortmyerssmiles.com](http://www.fortmyerssmiles.com)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

**Patient Information:**

Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 Sex:  Male  Female      Martial Status:  Married  Single  Divorced  Widowed  
 Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Employment Status:  Full Time  Part Time  Retired

**Responsible Party (if someone other than the patient):**

Responsible Party is also a Policy Holder for Patient ( Primary Insurance Policy Holder  Secondary Insurance Policy Holder)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 Sex:  Male  Female      Martial Status:  Married  Single  Divorced  Widowed  
 Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
 Email: \_\_\_\_\_

Does Patient have Dental Insurance?  No  Yes (If yes, please fill out information below)

**Is the patient the policy holder?  Yes  No (If no, please fill out Responsible Party Section)**

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
 Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_