Waco Dental and Denture Care, P.A.
Dr. Dana W. Chudej, DDS, FAGD
901 N. Loop 340, Suite 5
Waco, Texas 76705
(254) 799-5000

Today's Date: _____

ID: _____

Chart ID: _____

New Patient Registration

Please complete this form. If you have dental insurance, we cannot file a claim for you unless the requested information is accurate. If you have dual dental insurance coverage, complete the information for the secondary carrier. Thank you for your attention to detail.

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security #: _____ Driver's License #: _____
Sex: □ Male □ Female Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: (___)_____ Work Phone #: (___)_____ Cell Phone #: (___)_____
E-mail: _____
Patient's Employer: _____

Primary Insurance – Insured's Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security No.: _____
Insured's Employer: _____
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: (___)_____ Work Phone #: (___)_____ Cell Phone #: (___)_____

Primary Insurance Information:

Insurance Carrier: _____
Group ID #: _____ Member ID #: _____
Claims Submission Address: _____ Suite: _____
City: _____ State: _____ Zip Code: _____
Claims Phone #: (____)_____

Secondary Insurance – Insured's Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security No.: _____
Insured's Employer: _____
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: (___)_____ Work Phone #: (___)_____ Cell Phone #: (___)_____

Secondary Insurance Information:

Insurance Carrier: _____
Group ID #: _____ Member ID #: _____
Claims Submission Address: _____ Suite: _____
City: _____ State: _____ Zip Code: _____
Claims Phone #: (____)_____