Patient Registration Form

Patient's Name (First, Last): ______________________ Birth Date: ______________ Age: ________

Sex: M F Marital Status: Single Married Other______________ SSN: ______________________

Driver's License #: ______________________ Email (optional): ______________________

Address: ______________________ City______________ Zip________

Home #:______________________ Cell #: ______________________

Emergency Contact Name: ______________________ Phone #: ______________________

Reason for Visit: ______________________ Referred by: ______________________

GUARANTOR / GUARDIAN (IF APPLICABLE)

Name (First, Last): ______________________ Relationship to Patient: ______________________

Address: ______________________ City______________ Zip ________

Home #: ______________________ Cell #: ______________________

Driver's License #: ______________________ SSN: ______________________

DENTAL INSURANCE INFORMATION

Insurance Company Name: ______________________ Insurance ID #: ______________________

Insurance Company Address: ______________________ City______________ Zip ________

Insurance Company Phone #: ______________________ Employer ______________________

Group Name: ______________________ Group #: ______________________

If subscriber is different from patient, please fill out information below:

Subscriber Name (First, Last): ______________________ SSN: ______________________

Relationship to Patient:______________________ Birth Date: ______________________

Address: ______________________ Phone #: ______________________

SECONDARY INSURANCE: Dental Medical

Insurance Company Name: ______________________ Insurance ID #: ______________________

Insurance Company Address: ______________________ City______________ Zip ________

Insurance Company Phone #: ______________________ Employer ______________________

Group Name: ______________________ Group #: ______________________

If subscriber is different from patient, please fill out information below:

Subscriber Name (First, Last): ______________________ SSN: ______________________

Relationship to Patient:______________________ Birth Date: ______________________

Address: ______________________ Phone #: ______________________

FEES & PAYMENTS POLICY ACKNOWLEDGMENT

By signing below, I attest that I understand and authorize the following: I understand my insurance coverage is not a substitute for payment. I understand some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance companies. I authorize release of any information and records concerning my (or my dependent's) health care, advice, and treatment for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment(s) directly to the doctor named of the benefits otherwise payable to me.

Signature: ______________________ Today's Date: ______________________