PATIENT REGISTRATION

Date:_____ Date of Birth: _____

Patient Name_____ SS #:_____

☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address Street:_____

City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Business: ( ) _____

Mobile: ( )_____ Email: _____

Employer _____

If patient is a minor, who is legally responsible? _____

SS#_____ DOB _____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Referred by: _____

Method of Payment: ☐ Cash ☐ Check ☐ Visa or Mastercard

INSURANCE INFORMATION

Is treatment covered by insurance? ☐ Yes ☐ No

Name of Insurance Company_____ Phone:( )_____

Insurance Address:_____

Subscriber's Name: _____ SS#: _____

Date of Birth: _____ Patient's Relationship to Subscriber:_____

Subscriber's Employer:_____ Group or Policy Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Secondary Insurance Company _____ Phone: ( )_____

Insurance Address:_____

Subscriber's Name: _____ SS#: _____

Date of Birth::_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer:_____ Group or Policy Number: _____

I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received the financial agreement for insurance.

_____

Patient or Guardian Signature