PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Preferred name _____
Last *First* *Middle*
Address _____ Apt # _____ City _____ State ___ Zip _____
Phone: Home _____ Work _____ Cell _____ Employer _____
Birth date _____ Social Security # _____ If over 18, full time student? Y N Sex: M F
Who may we thank for referring you to our office? _____ Today's date _____
Family members seen previously at this office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last *First* *Middle*
Residence Street _____ Apt #_____ City_____ State ___ Zip _____
Mailing Address: St. _____ Apt # _____ City _____ State ___ Zip _____
Relation to patient _____ Phone: Home _____ Work _____Cell _____
Social Security # _____ Birth date_____ Driver's license # _____
Employer _____ Occupation _____No. of years _____
Employer Address _____
Spouse's Name _____ Social Security # _____
Last *First* *Middle*
Birth date _____ Phone: Work _____ Cell _____
Employer _____ Occupation _____ No. of years _____

EMERGENCY CONTACT: RELATIVE NOT LIVING WITH YOU

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work _____ Cell _____

DENTAL INSURANCE – PRIMARY CARRIER

Policy holder _____ S.S.N. _____ D.O.B. _____
Last *First* *M I*
Insurance Co. _____ ID # _____ Group #_____ Phone _____
Insurance Claims Address _____

DENTAL INSURANCE – SECONDARY CARRIER

Policy holder _____ S.S.N. _____ D.O.B. _____
Last *First* *M I*
Insurance Co. _____ ID # _____ Group #_____ Phone _____
Claims Mailing Address _____

This is a fee for service office. Payment is due at the time of services. If you have insurance, your estimated portion is due at that time. There is a $25 fee for returned checks. **Insurance submissions returned due to incorrect information will result in a $10 fee assessed to your account for resubmission.**

I have read and understand the financial policies of this office. **I understand that, regardless of my insurance status, I am responsible for this account.** I certify that the foregoing information is true and accurate to the best of my knowledge.

Date _____ Patient or Parent/Legal Guardian signature _____