REGISTRATION FORM

PATIENT INFORMATION: **DATE:** ____________________

Name: ____ Social Security: ______________

Address: ______________________________ City: ____________ State _____ Zip: ________

Phone: _______-_______ Work Phone: _______-_______ Birthday ____________ Age: ________

E-Mail Address: ______________ @ ______________ Cell Phone: ______________

Circle: Male / Female, Single / Married Employer: ______________________

The office calls to confirm your appointment 2 days prior, between 6-8pm, how do you wish to receive your confirmation: circle: home phone / cell phone / email

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT):

Name: ____ Social Security: ______________

Address: ______________________________ City: ____________ State _____ Zip: ________

Phone _______-_______ Work Phone: _______-_______ Birthday ____________ Age: ________

E-Mail Address: ______________ @ ______________ Cell Phone: ______________

Circle: Male / Female, Single / Married Employer: ______________________

PRIMARY CARE PHYSICIAN/SPECIALIST INFORMATION:

Primary Care Physician: ______________________________ Phone: ( ) _______-_______

DENTAL INSURANCE INFORMATION:

Primary Insurance: ______________________
Phone: ______________________
ID# ______________ Group# __________
Insured Name: ______________________
Insured Employer: ______________________
Insured Birthdate: ______________ Male / Female
Social Security: ______________________
Relationship to Patient: ______________________

Secondary: ______________________
Phone: ______________________
ID# ______________ Group# __________
Insured Name: ______________________
Insured Employer: ______________________
Insured Birthdate: ______________ Male / Female
Social Security: ______________________
Relationship to Patient: ______________________

REASON FOR VISIT: ____

How did you hear about us? Circle: Patient / Verizon / Yellow Book / Internet / Doctor

EMERGENCY CONTACT:

Incase of emergency contact: ______________________________ Phone: ( ) ______________

Relationship: ______________________________

I assign this office all my rights and benefits under my insurance contracts for payment for services rendered to me by this office. I authorize all information regarding my benefits under any insurance policy relating to any claims by this office be released to the office. I authorize this office to file insurance claims on my behalf. I direct that all payments go directly to this office. <u>I agree to pay the day services are rendered. The office does not bill your co-payments for services rendered. I understand that if for any reason my dental insurance does not make expected payment or if my insurance is terminated, I will be responsible for the TOTAL FEE.</u> I understand this assignment of benefits, and all information given is correct to my knowledge.

Patient/Guardian Signature: ______________________________ Date: ______________