

Patient Registration

Patient Name: _____ **Social Security Number:** _____

Date of Birth: _____ **Sex: M / F** (Circle one) **Married/Single/Divorced**

Street _____ **Clity** _____ **State** _____
Zip _____

Home Phone (____) _____ **Work Phone(____)** _____

Email Address: _____

How did you hear about our Practice? _____

Person responsible for bill or parent (Complete only if different from the patient)

Guarantor Name: _____ **Social Security Number:** _____

Relationship to Patient: Self ____ Spouse ____ Parent ____ Date of Birth: _____

Address: _____ **Phone Number:** _____

Employer Name: _____ **Employer Number:** _____

PRIMARY DENTAL INSURANCE

Insurance Company Name _____ **Employer** _____

Group/Policy Number _____

Policy Holder Name _____ **SS#** _____ **Birth Date** _____

SECONDARY DENTAL INSURANCE

Insurance Company Name _____ **Employer** _____

Group/Policy Number _____

Policy Holder Name _____ **SS#** _____ **Birth Date** _____

EMERGENCY CONTACT (not living with you)

Name _____ **Address** _____

Relation _____ **Phone Number (____)** _____

PLEASE READ AND SIGN

Regardless of insurance coverage (if applicable), I understand that all charges incurred by myself and/or dependents are my responsibility.

It is my responsibility to know my insurance policy benefits, limitations and maximums.

I authorize the release of any information needed to file insurance claims on my behalf.

I am aware that any balance carried past 90 days will accrue interest at an annual Rate of 29.9% and is subject to being turned over to a professional collection agency.

Signature _____ *Date* _____
