PATIENT REGISTRATION

Welcome to our office! In order to accurately maintain your financial records, please complete both sides of this form. All information is completely confidential.

Patient Information Date _____

Name _____ Age _____ Male ☐ Female ☐

Address _____ Social Security # _____

City _____ State _____ Zip _____ Phone (Home) _____ (Work) _____

Date of Birth _____ Drivers License # _____ Married ☐ Single ☐ Divorced ☐ Widowed ☐

If this appointment is for your child, complete the following:

Name _____ Date of Birth _____ Age _____ Male ☐ Female ☐

Address _____ Home Phone _____

City _____ State _____ Zip _____ School _____ Grade _____

Insurance Information

Primary Carrier:

Insurance Company _____ Employee _____ Date of Birth _____

Social Security # _____ Group # _____ Date Employed _____

Secondary Carrier:

Insurance Company _____ Employee _____ Date of Birth _____

Social Security # _____ Group # _____ Date Employed _____

Account Information

Person financially responsible for this account _____ Relationship to Patient _____

Address (if different from patient) _____ Phone _____

Employer _____ Business Phone _____ Business Address _____

Emergency Contact

Is another member of your family or relative a patient at our office? Yes ☐ No ☐ Their Name _____

Person to contact in case of emergency _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referred By

So that we can thank them, who referred you to our office? _____

I understand responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% finance charge (18% annual percentage rate) may be added to my account.

Patient Signature _____ Date _____

Parent/Responsible Party Signature _____ Date _____

PLEASE COMPLETE OTHER SIDE

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

PATIENT NAME _____
LAST FIRST INITIAL

I authorize the office of _____ to submit claims for payment for services to the health care service plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance benefits.

1. _____
INSURANCE COMPANY

2. _____
INSURANCE COMPANY

3. _____
INSURANCE COMPANY

_____
NAME (PATIENT, PARENT, OR GUARDIAN)

_____
SIGNATURE (PATIENT, PARENT, OR GUARDIAN)

_____
DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____
LAST FIRST INITIAL

I authorize the office of _____ to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

_____
NAME (PATIENT, PARENT, OR GUARDIAN)

_____
SIGNATURE (PATIENT, PARENT, OR GUARDIAN)

_____
DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.