

## Patient Registration & Insurance

Patient Name _____	Date _____	
Last                    First                    Middle		
Prefers to be called _____		
Address _____	Birth Date _____	
City _____	Zip _____	Home Phone _____
E-Mail _____	Cell Phone _____	
Where do you prefer to be called? _____		
<i>Please circle:</i> Marital status: S M W D other	Patient's Sex: Male Female	

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_ May we call you at work? Yes No

Spouse's Name (or parent if the patient is a minor) \_\_\_\_\_

Spouse's Address ("same" is acceptable) \_\_\_\_\_

Spouse's Employer & Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_ May we call them at work? Yes No

Your Social Security # \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

Whom should we contact in case of emergency? \_\_\_\_\_

Phone \_\_\_\_\_

Person financially responsible for account \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice?

- Another patient, friend     Another patient, relative     Dental Office     Yellow Book
- AT&T Yellow Pages     Newspaper     Welcome Wagon     Direct Mail     School
- Work     Other \_\_\_\_\_

Name of person or office referring you to our practice:

\_\_\_\_\_

**Complete this section if you have dental insurance (s)**

Primary Insurance

Insured's Name \_\_\_\_\_

Group # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

SS#/Insurance ID# \_\_\_\_\_

Secondary Insurance

Insured's Name \_\_\_\_\_

Group # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

SS#/Insurance ID# \_\_\_\_\_

**READ CAREFULLY AND UNDERSTAND WHAT YOUR SIGNATURE MEANS.** Your signature below serves many purposes. It indicates you have reviewed your medical history and updated and corrected it as appropriate. It also indicates you have reviewed your personal registration information above (especially your phone numbers) to ensure that it is correct. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits and the release of information to all my insurance carriers. And finally, the undersigned agrees, whether or not he/she is insured, that in consideration of the services rendered to the patient, he or she individually obligates themselves to pay this account upon receipt of the initial bill for the above mentioned services and/or acknowledges that he or she is primarily responsible for payment of the account notwithstanding the existence of other sources of payment, unless previous financial arrangements have been made with the Financial Coordinator. A 1.5% (18% APR) monthly service charge is assessed on ALL balances over 30 days. Your signature also is a promise that you will keep all scheduled appointments.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_