Patient Registration Form

Date: ____________________

Name ____________________________ Mr. Mrs. Ms. Miss Dr. Rev.

Address ________________________________ City ____________________ State ________ Zip _______________

Date of Birth _____/_____/_____ Marital Status S M D W Home Phone (____)________________

Soc. Security # ______-______-______ Sex M or F Work Phone (____)_________________

E-mail ______________________________@_________________ Cell Phone (____)_________________

Employer Name & Address ___________________________________ Occupation _________________________

Spouse Name ____ Spouse Date of Birth _____/_____/_____

Emergency Contact ____ & Phone Number (____)________________

How Did you hear about our office? ____

Dental Insurance Information

Insurance Subscriber ________________________ Relationship _______________ Date of Birth _____/_____/_____

Employer Name and Address ____ ID #___________________________

Dental InsuranceCo. ________________________________ Address ____

Phone # of Insurance Co. ___(____)________________ Policy/Group #_______________________________________

Secondary Dental Coverage? YES or NO If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. You are responsible for all co-payments before secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Secondary Insurance Co. Name, Address, and Phone ____

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I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize the release of information as it relates to my dental treatment and my insurance coverage. I also acknowledge that I have received a copy of the office “Privacy Policy” as required by the Health Insurance Portability & Accountability Act (HIPPA).

Signature ____ Date __________________

Please complete other side of this form with your Dental and Medical History