

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Social Security No. _____
Last First M.I.
Home Address _____
Street City State Zip
Mailing Address (if different) _____ Email: _____
Date of Birth _____ Sex M F Marital Status M S D W O Home Phone (____) _____ Cell Phone (____) _____
Employer's Name _____ Work Phone (____) _____
Referring Doctor _____ Phone (____) _____
General Dentist _____ Phone (____) _____
Primary Care Doctor _____ Phone (____) _____
Orthodontist _____ Phone (____) _____

PERSON RESPONSIBLE FOR PAYMENT/ SPOUSE OR PARENT/ IF MINOR, PARENT OTHER THAN LISTED ABOVE

Name _____ Relationship to patient _____ Soc. Sec. No. _____
Last First M.I.
Date of Birth _____ Address (if different) _____
Street City State Zip
Home Phone (____) _____ Employer _____ Phone (____) _____

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE)

Name _____ Relationship _____ Phone No. (____) _____
Last First M.I.
Address _____ Work Phone. (____) _____
Street City State Zip

MEDICAL INSURANCE (NEED COPY OF CARD)

Primary Insurance _____ Group No. _____ ID No. _____
Subscriber's Name _____ Relationship to patient _____ Employer _____
Subscriber's SS# _____ D.O.B. _____

Secondary Insurance _____ Group No. _____ ID No. _____
Subscriber's Name _____ Relationship to patient _____ Employer _____
Subscriber's SS# _____ D.O.B. _____

DENTAL INSURANCE

Dental Insurance _____ Group No. _____ ID No. _____
Subscriber's Name _____ Relationship to patient _____ Insured's Date of Birth: _____
Subscriber's SS# _____ D.O.B. _____

INJURY INFORMATION

Attorney: _____ Date of Injury: _____
Law Firm: _____ Auto Accident: Yes or No
Phone: (____) _____ On The Job Injury: Yes or No

WORKER'S COMPENSATION COMPANY / MVA:

Case Worker Name: _____ Phone: (____) _____
Company Name: _____ Claim No. _____

I hereby authorize my physician to release any medical information necessary to process claims with any insurance companies. I also assign my physician all payments to which I am entitled for medical and surgical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee. Privacy Notice. I approve transfer of Medical and Dental records by email to my treating Dentist and Physicians.

X	_____ SIGNATURE	<input type="checkbox"/> UPDATE	RELATIONSHIP TO PATIENT	DATE
X	_____ SIGNATURE	<input type="checkbox"/> UPDATE	RELATIONSHIP TO PATIENT	DATE
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