PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ (Last / First / M.I.) Social Security No. _____

Home Address _____ (Street / City / State / Zip)

Mailing Address (if different) _____

Date of Birth _____ Sex M F Marital Status M S D W O Home Phone (___) _____

Employer's Name _____ Work Phone (___) _____

Referring Doctor _____ Phone (___) _____

General Dentist _____ Phone (___) _____

Primary Care Doctor _____ Phone (___) _____

Orthodontist _____ Phone (___) _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ (Last / First / M.I.) Relationship to patient _____ Soc. Sec. No. _____

Date of Birth _____ Address (if different) _____ (Street / City / State / Zip)

Home Phone (___) _____ Employer _____ Phone (___) _____

SPOUSE OR PARENT (IF MINOR, PARENT OTHER THAN LISTED ABOVE)

Name _____ (Last / First / M.I.) Relationship _____

Address _____ (Street / City / State / Zip)

Home Phone (___) _____ Work Phone (___) _____

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE)

Name _____ (Last / First / M.I.) Relationship _____ Phone No. (___) _____

Address _____ (Street / City / State / Zip) Work Phone. (___) _____

MEDICAL INSURANCE (NEED COPY OF CARD)

Primary Insurance _____ Group No. _____ ID No. _____

Insured Name _____ Relationship to patient _____ Employer _____

Secondary Insurance _____ Group No. _____ ID No. _____

Insured Name _____ Relationship to patient _____ Employer _____

DENTAL INSURANCE

Dental Insurance _____ Group No. _____ ID No. _____

Insured Name _____ Relationship to patient _____ Insured's Date of Birth: _____

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.

X _____ SIGNATURE	❑ UPDATE	RELATIONSHIP TO PATIENT	DATE
X _____ SIGNATURE	❑ UPDATE	RELATIONSHIP TO PATIENT	DATE
X _____ SIGNATURE	❑ UPDATE	RELATIONSHIP TO PATIENT	DATE