PATIENT REGISTRATION FORM

1. GENERAL INFORMATION

Name:_____
Home Address:_____
_____
Home #:_____
Work #:_____Ext.:_____
Cell #_____
□ Male □ Female Student Status: □F □P
Marital Status: □M □S □D □W
D.O. B._____ Age: _____
S.S.#: _____
Employer Name:_____
Employer Address:_____
_____

2. PERSON RESPONSIBLE FOR ACCOUNT

(If patient is a minor)

Name:_____
Address:_____
_____
Home #:_____
Work #:_____Ext.:_____
Cell #:_____
Relationship:_____
S.S.#_____D.O.B._____

3. EMERGENCY CONTACT PERSON

Name:_____
Home #:_____Cell #:_____
Work #:_____Ext.:_____

4. REFERRAL INFORMATION

Who referred you to our office?

_____

CONSENT FOR TREATMENT

I consent to oral surgery and the use of local or general anesthesia as indicated, and certify that the medical history I have given is correct to the best of my knowledge. I further acknowledge that I have read and understand the Notice of Privacy Policies and Practices.

5. INSURANCE INFORMATION

DENTAL INSURANCE INFO.:

Insurance Co.:_____
Address: _____
_____
Subscriber Name:_____
Subscriber D.O.B.:_____
Subscriber S.S.#:_____
Subscriber Relationship to Patient:_____
Subscriber Employer:_____

MEDICAL INSURANCE INFO.:

Insurance Co.:_____
Address: _____
_____
Subscriber Name:_____
Subscriber D.O.B.:_____
Subscriber S.S.#:_____
Subscriber Relationship to Patient:_____
Subscriber Employer:_____

6. INS/PAYMENT AGREEMENT

I Authorize:

- use of this form for all my insurance submissions.
- release of information to all my insurance co.s
- this office to act as my agent in obtaining payment from my insurance company
- a copy of this authorization to be used in place of original
- payment directly to the doctor. If I receive any insurance payments I agree to sign the check(s) over to the doctor
- all recommended testing is my responsibility

I understand that I am responsible for my bill and that insurance claims for services do not alter my responsibility to pay my account. I agree that this contract will remain in force for all services regardless of the date signed. There will be a $35.00 fee imposed for checks returned for any reason.

X_____
Signature

X_____
Date