PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Apt#: _____
City, State, Zip: _____
Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
Email Address: _____@_____
Birth Date: __/__/_____ SS #: _____-_____-_____
Martial Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
Employment Status: [ ] Full Time [ ] Part Time [ ] Retired
Student Status: [ ] Full Time [ ] Part Time
What is the best way to contact you?
[ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] Text Message [ ] Email
[ ] Facebook [ ] Other method: _____
Who may we thank for referring you to our office?_____

Responsible Party (if someone other then the patient):

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Apt#: _____
City, State, Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____
Email Address: _____@_____
Birth Date: ___/___/___ SS#: _____-_____-_____
[ ] Responsible Party is also a Policy Holder for Patient
[ ] Primary Ins. Policy Holder OR [ ] Secondary Ins Policy Holder

Primary Insurance Information:

Name of Insured: _____ Birth Date: ___/__/__ SS#: ____-____-____
Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Birth Date: ___/__/__ SS#: ____-____-____
Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Dental Insurance

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Appointment Cancellation Policy

Any appointment not cancelled 24 hours prior to appointment may be charged a broken appointment fee.
I have read and understand the above statements:

Patients Signature: _____ **Date:** _____