PATIENT REGISTRATION

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: ____
CITY/ST/ZIP: _____ SOCIAL SECURITY NO.: _____
MARITAL STATUS: ___Single ___Married ___Divorced ___Separated ___Widowed EMAIL: _____
EMPLOYER: _____ WORK PHONE NO.: _____
ADDRESS: _____ CITY/ST/ZIP: _____

SPOUSE INFORMATION

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: ____
CITY/ST/ZIP: _____ SOCIAL SECURITY NO.: _____
EMPLOYER: _____ WORK PHONE NO.: _____
ADDRESS: _____ CITY/ST/ZIP: _____

GUARANTOR INFORMATION

(if different from patient)

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: ____
CITY/ST/ZIP: _____ SOCIAL SECURITY NO.: _____
MARITAL STATUS: ___Single ___Married ___Divorced ___Separated ___Widowed
EMPLOYER: _____ WORK PHONE NO.: _____
ADDRESS: _____ CITY/ST/ZIP: _____
PREVIOUS EMPLOYER: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____
NAME OF POLICY HOLDER/SUBSCRIBER: _____
MEMBER NO.: _____ GROUP NO.: _____ PLAN NO.: _____
SECONDARY INSURANCE CARRIER: _____
NAME OF POLICY HOLDER/SUBSCRIBER: _____
MEMBER NO.: _____ GROUP NO.: _____ PLAN NO.: _____

OTHER INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU? _____
RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF AN EMERGENCY: _____
ADDRESS: _____
CITY/ST/ZIP: _____ HOME PHONE NO.: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay 25% collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

SIGNED (patient): _____ DATE: _____
SIGNED (guarantor): _____ DATE: _____