ProDent Care
Modern Dentistry with a Caring Touch

Patient Registration

Print Form

Referred by:

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL QUESTIONS COMPLETELY.

Patient Information

Patient's Last Name _____ First Name _____ Initial _____

Home Address _____ City _____ State _____ Zip _____

DOB _____ Social Security No. _____ Gender ? ☐ Male ☐ Female

Home Phone _____ Cell _____ Driver's License #/ID: _____

Is patient a student? ☐Yes ☐No If yes: ☐PT ☐FT Provide school name & address: _____

e-mail _____ Consent to use ? ☐ Yes ☐ No

Emergency contact Name ? _____ Relationship ? _____ Phone _____

Responsible Person Information

☐ If Same as Patient, Please Skip This Section

Relationship to Patient ? _____

Last Name _____ First Name _____ Initial _____

Home Address _____ City _____ State _____ Zip _____

DOB _____ Social Security No. _____ Gender ? ☐ Male ☐ Female

Home Phone _____ Cell _____

e-mail _____ Consent to use ? ☐Yes ☐ No

Employer Information

Employer Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Primary Dental Insurance Information

☐ If NO Dental Insurance, Please Skip Insurance Sections

Employer Name _____

Insured Last Name _____ First Name _____ Initial _____

DOB _____ Social Security No. _____

Insurance Name _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Subscriber ID _____ Group Number _____

Secondary Dental Insurance Information

☐ If NO Dental Secondary, Please Skip This Section

Employer Name _____

Insured Last Name _____ First Name _____ Initial _____

DOB _____ Social Security No. _____

Insurance Name _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Subscriber ID _____ Group Number _____

AUTHORIZATION

I hereby authorize payment directly to ProDent Care, Dental Practice of TEREZA HAMBARCHIAN, D.D.S., Inc. of all insurance benefits. I understand that I am financially responsible for all costs whether or not paid by my insurance. I hereby authorize the release of all information necessary to secure the payment of benefits.

Responsible Person Signature _____ Date: _____

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