Patient Registration Form

Patient Information

Patient Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Date of Birth: _____ SS#: _____

Sex: _____ Marital Status: _____

Employer: _____ Referred By: _____

Email Address: _____

Responsible Party (if not yourself): _____

Spouse's Information

Name: _____

Home #: _____ Cell #: _____ Work #: _____

Date of Birth: _____ SS#: _____

Employer: _____

Insurance Information

Primary Insurance

Insurance Co.: _____

Address: _____

_____

_____

Phone #: _____

Group #: _____

Insured ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

Secondary Insurance

Insurance Co.: _____

Address: _____

_____

_____

Phone #: _____

Group #: _____

Insured ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

I understand that I am responsible for the fees that I incur at this office. If I have dental insurance, I am responsible for the deductible and estimated out of pocket expense at the time of the appointment, if, after 60 days my insurance has not paid, I am responsible for the remainder of the balance.

Signature of Patient: _____