Patient Registration
CONFIDENTIAL

Patient Information

Name_____ (_____) Date of Birth_____
First MI Last Nickname

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

E-Mail Address_____ I prefer to be called at ❑Home ❑Work ❑Cell ❑Any

Are you: ❑Male ❑Female

❑Minor_____ ❑Single ❑Married_____ ❑Divorced ❑Separated ❑Widowed
Parents' names Spouse's name

Employer (or School, if minor)_____ Occupation_____

Social Security Number_____ Whom may we thank for referring you?_____

Other Family members in the practice:_____

Person to contact in case of an emergency:_____
Name Phone Relationship

Responsible Party

Complete this section if responsible party is someone other than the patient.

Name_____ Date of Birth_____ Relationship to patient_____
First Last

Social Security Number_____ Employer_____
Name Phone

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Currently a patient in this office? ❑Yes ❑no

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 2.5% (25% APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made.

Responsible Party's Signature_____ Date_____

Dental Benefit Information

If you have no dental benefits disregard this section.

Primary Plan

Name of Policy Holder_____
Address_____
Phone_____ E-Mail_____
Birthdate_____ Relationship to patient_____
Social Security Number_____
Employer_____
Insurance Co. Name_____
Insurance Co. Address_____
Group Number_____ ID #_____

Secondary Plan

Name of Policy Holder_____
Address_____
Phone_____ E-Mail_____
Birthdate_____ Relationship to patient_____
Social Security Number_____
Employer_____
Insurance Co. Name_____
Insurance Co. Address_____
Group Number_____ ID #_____

I hereby authorize benefit payment directly to Dr. Brad Welsh's Office. I authorize this office to release any information my insurance company asks for, such as radiographs, dental history, and office/clinical notes. I understand that I am ultimately responsible for all costs of dental treatment.

_____ _____
Primary Policy Holder Signature Secondary Policy Holder Signature