

PATIENT REGISTRATION

Patient Information

Name: _____ Preferred Name: _____ S.S. #: _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cellular Phone: _____ Email: _____

Birth Date: _____ Sex: Male ___ Female ___ Responsible Party: Yes ___ No ___

Responsible Party if Different From Above

Name: _____ Preferred Name: _____ S.S.#: _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cellular Phone: _____ Email: _____

Birth Date: _____ Sex: Male ___ Female ___ Responsible Party: Yes ___ No ___

Primary Dental Insurance Information

Name of Insured: _____ Insured S.S.#: _____
Last First MI

Subscriber Number: _____ Group Number: _____

Birth Date: _____ Patient Relationship: Self ___ Spouse ___ Child ___ Other ___

Insurance Company: _____ Insurance Company Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Secondary Insurance Subscribers

We do not accept 'assignment of benefits' for secondary insurance. If you have secondary insurance we will assist you in filing a claim after the primary insurer has made payment and your account balance is paid in full. If you wish to have us assist you in filing your secondary claim, please ask our account manager for assistance. If you are unsure which insurance is primary, present both cards to our account manager and we can assist you.