

PATIENT REGISTRATION

NAME:			DATE:		
DOB	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D		
SS#		E-MAIL ADDRESS			
ADDRESS					
PHONE (HOME)		(WORK)	(CELL)		(OTHER)
EMPLOYER NAME		ADDRESS			PHONE
PARENT/LEGAL GUARDIAN (IF MINOR)					
REFERRING DENTIST/PHYSICIAN					
CONTACT PERSON NOT LIVING WITH YOU					
PERSON RESPONSIBLE FOR THIS ACCOUNT					
ADDRESS			PHONE		
RESPONSIBLE PARTY'S SS#		DOB	DL#		

WOULD YOU LIKE FOR US TO BILL YOUR INSURANCE? YES NO

PRIMARY DENTAL INSURANCE	PRIMARY MEDICAL INSURANCE
INS. CO.	INS. CO.
ADDRESS	ADDRESS
PHONE NO.	PHONE NO.
GROUP #	GROUP #
INSURED'S NAME	INSURED'S NAME
RELATION SS#	RELATION SS#
INSURED'S EMPLOYER	INSURED'S EMPLOYER
SECONDARY DENTAL INSURANCE	SECONDARY MEDICAL INSURANCE
INS. CO.	INS. CO.
ADDRESS	ADDRESS
PHONE NO.	PHONE NO.
GROUP #	GROUP NO.
INSURED'S NAME	INSURED'S NAME
RELATION SS#	RELATION SS#
INSURED'S EMPLOYER	INSURED'S EMPLOYER

I certify that the foregoing statements are true and correct and authorize any medical information necessary to process my claim.	I authorize payment of medical benefits to the Oral Surgeon shown above for services described on claim.
---	--

Please note: Patients are billed from date of service, regardless of insurance coverage. Therefore, payments are expected within 30 days of your date of service. Any refunds required, due to insurance payment, are mailed out at the end of each month.

ACKNOWLEDGED AND AUTHORITY

I acknowledge full responsibility for the payment of all services and agree that I will take responsibility for all costs incurred by my failure to remit for services rendered. I have read and understand HIPPA Compliance.

Signed _____
Patient, Parent, or Responsible Party