PATIENT REGISTRATION

PATIENT

First Name_____ Middle I._____ Last Name_____

Circle one: Mr. Mrs. Ms. Dr. Other_____ Name by which you prefer to be called_____

Patient is: Policy Holder___ Responsible Party___ Responsible party is also the policy holder for the patient___

If you are the responsible party and you are not the patient, please fill out this next section:

First Name_____ Last Name_____

Address 1_____ Address 2_____

City, State, Zip_____

Home Phone_____ Work Phone_____ Ext_____ Cell_____

Birth Date_____ Social Security #_____ Driver's Lic. #_____

PATIENT INFORMATION

Home Addr._____ Work Addr._____

City, State, Zip_____ City, State, Zip_____

Sex: Male__ Female___ **Marital Status:** Circle One: Single Married Divorced Separated Widowed

Home Phone_____ Work Phone_____ Ext._____ Cell_____

Age_____ Birth date_____ Social Security #_____Driver's Lic. #_____

E-mail address_____ I would like to receive correspondence by e-mail: Yes___ No___

I would like to receive correspondence by text: Yes___ No___

Please be assured that we will not disclose your e-mail address to anyone!

How did you hear about our office? _____

Whom may we thank for referring you? _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____Relation to patient: Self___ Spouse___ Child___ Other___

Insured's Date of Birth _____ Insured's Social Security #_____

Employer _____ Insurance Co._____

Address 1_____ Address 1_____

Address 2_____ Address 2_____

City, St, Zip_____ City, St., Zip_____

I, the undersigned, have insurance with _____ and assign directly to Dentistry at Sugarloaf all benefits otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance company and that I am financially responsible for all charges, whether or not paid by my insurance. I also understand you will provide me with a "best guess "as to what my insurance company will pay, and that it is not a guarantee of actual payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____