Shelby Family Cosmetic & Restorative Dentistry

REGISTRATION FORM

Today's Date: [Date]	PCP: [PCP]

PATIENT INFORMATION

Patient's last name: First:	Middle: [Choose an item]	Marital status: [Choose an item]

Is this your legal name? ○ Yes ○ No	Social Security no.: [SS#]	Address	Birth date:	Age:	Sex: ○ M ○ F

Email address:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Would you lie to receive text messages as a reminder for future appointments? yes or No

May we contact you at work? yes or No

Pharmacy #_____

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: [Responsible party]	Birth date: [Birthday]	Address (if different): [Address]	Home phone no.: [Phone]
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]	Employer phone no.: [Phone]

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name: [Name]	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.: [Group #]	Policy no.: [Policy #]	Co-payment: $[Co-pay]

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable): [Secondary Insurance]	Subscriber's name: [Name]	Group no.: [Group #]	Policy no.: [Policy #]

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): [Friend or relative name]	Relationship to patient: [Relationship]	Home phone no.: [Phone]	Work phone no.: [Phone]

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Shelby Family Cosmetic & Restorative Dentistry or insurance company to release any information required to process my claims.

I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me.

I grant the right to the dentist release mu dental records to other medical and other health professionals, as appropriate under the circumstances

I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them in FULL AT THE TIME OF SERVICE, unless other financial arrangements with the practice professionals.

Patient/Guardian signature

Date