PATIENT REGISTRATION

Today's Date: ______________________

Name: ____
FIRST LAST MIDDLE

I prefer to be called: ____________________ ❑ Male ❑ Female

Birthdate: ___ /___ /___ Age: ______ SS#: ________________

Home Address: ____

____

City ____________________ State ________ Zip ______

Home Phone: (___) ____________ Cell #: (___) ____________

Work Phone: (___) ____________ Ext.: ______

Which phone number should we use to confirm appts.? ____________

Email: ____

Employer: ____

Occupation: ____

Full time College Student: ❑ Yes ❑ No

School ____________________ City ____________ State ______

How did you hear about our office?

____

Spouse Information:

His/Her Name: ____

Employer: ____

Position: ________ Social Security #: ____________________

Work Phone: (___) ____________ Ext.: ______

Person Responsible for Account: (If other than yourself)

Name: ____

Billing Address: ____

____

Employer: ____

Work Phone: (___) ____________ Ext. ______

Home Phone: (___) ____________

Relationship: ____________ Social Security #: ____________________

In the event of an emergency, whom should we contact?

His/Her Name: ____________________ Relation: ____________________

Work Phone: (___) ____________ Home Phone: (___) ____________

Primary Dental Insurance ❑ YES ❑ NO

Insurance Co. Name: ____

Insurance Co. Address: ____

Insurance Co. Phone: (_____) ______________

Group Number (Plan, Local or Policy#): ______________________

Insured's Name: ____________________ Relation: ____________

Insured's Birthdate: ___ /___ /___ ID #: ____________________

Insured's Employer: ____

Secondary Dental Insurance ❑ YES ❑ NO

Insurance Co. Name: ____

Insurance Co. Address: ____

Insurance Co. Phone: (_____) ______________

Group Number (Plan, Local or Policy#): ______________________

Insured's Name: ____________________ Relation: ____________

Insured's Birthdate: ___ /___ /___ ID #: ____________________

Insured's Employer: ____

Authorization and Release

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I understand that providing incorrect information can be dangerous to my health. I authorize Highgrove Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Highgrove Dental Care the dental insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

Signature ______________________________

Date ______________________________

Thank you for filling out this form completely.
If you have any questions at any time, please ask us.

– Over–