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or www.PatelFamilyDentist.com

PATIENT REGISTRATION
(Please Print)

PATIENT INFORMATION

Name _____ Social Security No. _____
Address _____ Phone _____
City _____ State ____ Zip Code _____
Sex ❑ M ❑ F Birth date _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Patient Employed By _____ Business Phone _____
Address _____ Phone _____
e-Mail _____ Cell Phone _____
Address _____
Street City State Zip

PRIMARY INSURANCE

Subscriber Name _____ Relation to Patient _____
Social Security No. _____ Birth date _____
Address (if different than patient) _____
Street City State Zip
Insurance Company Name _____
Subscriber #: _____ Group #: _____
Insurance Company Address _____
Street City State Zip

ADDITIONAL INSURANCE

Is Patient covered by additional Insurance? ❑ Yes ❑ No
Subscriber Name _____ Relation to Patient _____
Social Security No. _____ Birth date _____
Address (if different than patient) _____
Street City State Zip
Insurance Company Name _____
Subscriber #: _____ Group #: _____
Insurance Company Address _____
Street City State Zip

REFERRED BY

Name _____ Address _____

ASSIGNMENT OF BENEFITS – RELEASE OF MEDICAL RECORDS

I hereby authorize direct payment of the amount due me as a result of my claim to the doctor or medical group whose name appears on the top of this from. I authorize the release of any information needed by my carrier to process the claim. I understand that I am financially responsible for all charges; these may include but not limited to deductibles; co-pays, and "non-covered services".

_____ _____ _____
Responsible Party Signature Relationship Date