patient registration

Thank you for choosing us – we appreciate your business!

SEMANS
FAMILY DENTISTRY

general information

First name:_______________ Date:_______________

Last name:_______________

How do you wish to be addressed:_______________

Address:_______________

City:_______________ State:_______________ Zip code:_______________

Phone: Home:_______________ Work:_______________ Cell:_______________

Preferred contact method: ❑ Home phone ❑ Work phone ❑ Cell phone ❑ Email

Email address:_______________

May we use your email address to send you important news? ❑ yes ❑ no

Occupation:_______________

Employer:_______________

Work address:_______________

City:_______________ State:_______________ Zip code:_______________

Spouse/parent/guardian name:_______________

Relationship:_______________ Birthdate:_______________ SS#_______________

Phone: Home:_______________ Work:_______________ Cell:_______________

Occupation:_______________ Employer:_______________

Other family members in this practice:_______________

Emergency contact information: [please specify someone not living in your household]

Name:_______________ Best time to reach you:_______________

Relationship:_______________ Phone:_______________

Gender: ❑ Male ❑ Female

Birthdate:_______________

SS#:_______________

Marital status:

❑ Single ❑ Married

❑ Widowed ❑ Separated

❑ Divorced

Referred by:_______________

dental insurance information

PRIMARY INSURANCE INFORMATION

Person responsible for this account:_______________

Subscriber's name:_______________

Relationship:_______________ Employer:_______________

Insurance company:_______________ Group #_______________

Birthdate:_______________ SS#:_______________

Is this patient covered by additional insurance? ❑ yes ❑ no

SECONDARY INSURANCE INFORMATION

Subscriber's name:_______________

Relationship:_______________ Employer:_______________

Insurance company:_______________ Group #_______________

Birthdate:_______________ SS#:_______________

assignment & release

I, the undersigned, authorize Dr. Semans to perform diagnostic procedures and treatment as may be necessary for proper dental care. I, the undersigned, certify that I [or my dependent] have insurance coverage and assign directly to Thomas D. Semans, DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Semans to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature:

____

Date: _______________

Relationship:_______________