PATIENT REGISTRATION FORM

Patients Name ____
Last Middle First

If Child, Parents Name
____
Last Middle First

Party Responsible for the account (if different from above)
____
Last Middle First

How do you wish to be addressed?____________________________

Address ____

City______________________ State________ Zip Code_________

How do you prefer appointment confirmations, ____phone ____ email

Email address____

Home Phone # ____

Work Phone #____

Cell Phone # ____

Social Security # ____

Date of Birth___________________ Sex ________M _________F

Single ____ Married ____ Separated ____ Divorced ____ Minor _____

Spouses Name ____

Other Family Members In This Practice _________________________

Referred by ____

Person Financially Responsible for Account _____________________

Emergency Contact ____

Emergency Contact Phone # _________________________________

Primary Dental Coverage

Employee Name _____________________________

Employee DOB____________ SS# ______________

Employer __________________________________

Employer Address ___________________________

Employer Phone ____________________________

Insurance Co. _______________________________

Insurance Co. Address ________________________

Insurance Co. Phone _________________________

Group/Plan # ______________________________

Member ID# _______________________________

Secondary Dental Coverage

Employee Name ____________________________

Employee DOB __________ SS# _______________

Employer _________________________________

Employer Address __________________________

Employer Phone ____________________________

Insurance Co. ______________________________

Insurance Co. Address _______________________

Insurance Co. Phone ________________________

Group/Plan # ______________________________

Member ID# ______________________________

RELEASE:

I authorize Dr. Semans to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance purposes.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits to Dr. Semans, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIANS SIGNATURE ____ **DATE** ______________