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:_____