PATIENT REGISTRATION

Please Complete The Following Confidential Information (both sides)

PATIENT INFORMATION

NAME DATE

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE BIRTHDATE

MALE ☐ ☐ MINOR ☐ SINGLE

FEMALE ☐ ☐ MARRIED ☐ WIDOWED

SOCIAL SECURITY #: _____

FULL TIME COLLEGE STUDENT: Y N NAME OF SCHOOL: _____

EMAIL ADDRESS: _____

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE CO. PHONE:

GROUP NO.

INSURED RELATIONSHIP TO PAT.

BIRTHDATE

UNION OR LOCAL NO.

SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE CO. PHONE:

GROUP NO.

INSURED RELATIONSHIP TO PAT.

BIRTHDATE

UNION OR LOCAL NO.

SOCIAL SECURITY NO.

METHOD OF PAYMENT

☐ Check ☐ Cash ☐ Credit Card ☐ Flex Plan Card

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME DRIVERS LIC. NO.

RELATIONSHIP TO PATIENT

ADDRESS *(if different from above)*

CITY STATE ZIP

HOME PHONE CELL PHONE

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY STATE ZIP

WORK PHONE CELL PHONE

SPOUSE

NAME DRIVERS LIC. NO.

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY STATE ZIP

WORK PHONE CELL PHONE

GETTING TO KNOW YOU

REFERRED TO US BY:

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: ***RELATIONSHIP:***

PERSON TO CONTACT IN CASE OF AN EMERGENCY

NAME: ***PHONE NO:***

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME: ***PHONE NO:***

ADDRESS

CITY ***STATE*** ***ZIP***

OFFICE FINANCIAL POLICY

Financial responsibility for services provided belongs to the patient or guardian. Our policy is to receive payment at the time service is provided unless another arrangement is specifically agreed upon in advance.

In the case of patients with dental insurance, our office provides insurance processing as a service, but ultimate responsibility for the account is yours. Any problems with collecting insurance benefits must be worked out between you and your insurer. Our policy is to collect your estimated share of the fee at the time service is provided.

I have read the financial policy statement above and agree to it's terms.

*Signature:*_____ *Date:*_____

I authorize my insurance to make payment directly to Dr. William B. Thomas for services provided

Signature:_____