PATIENT REGISTRATION

PATIENT_____
FIRST NAME MIDDLE INITIAL LAST NAME PREFERRED NAME

PHONE NUMBERS: **HOME**_____ **CELL PHONE** _____

STREET ADDRESS_____ **UNIT/APT #** _____

CITY_____ STATE_____ ZIP CODE_____

EMAIL_____ SEX: ___MALE ___FEMALE

BIRTHDATE_____ **SS#**_____ MARITAL STATUS _____

EMPLOYER_____ **EMPLOYER PHONE #**_____

SPOUSE NAME_____ BIRTHDATE_____ SS#_____

SPOUSE EMPLOYER_____ EMPLOYER PHONE #_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____

RELATIONSHIP TO PATIENT_____

RESPONSIBLE PARTY SS# _____ BIRTHDATE_____

EMPLOYER_____ EMPLOYER PHONE #_____

PRIMARY DENTAL INSURANCE COMPANY: _____

ID#_____ GROUP#_____ PAYOR ID_____

SECONDARY DENTAL INSURANCE COMPANY:_____

ID#_____ GROUP#_____ PAYOR ID_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?_____ PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

I ASSIGN DIRECTLY TO PURE DESIGN DENTISTRY ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED, FOR PAYING ANY CO-PAYMENT, DEDUCTIBLES AND ANY COLLECTION FEES INCURRED TO SECURE PAYMENT ON MY ACCOUNT. I HEREBY AUTHORIZE PURE DESIGN DENTISTRY TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

I UNDERSTAND THAT A $50 FEE MAY BE PLACED ON MY ACCOUNT FOR ANY MISSED APPOINTMENTS WITHOUT 48 HOUR NOTICE.

_____ _____ _____
DATE **NAME** **SIGNATURE**