PATIENT REGISTRATION FORM

WELCOME *Thank you for selecting our Dental Team! We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask – we will be happy to help.*

Name:______________________________________ Nickname: _________________________ Gender: M / F

SS#:_____________________ DOB: _____________ Driver License#: ______________________________

Address:____

City:____ State/Zip:_________________________________

Home Phone:_________________________________ Cell Phone:_______________________________

Work Phone:_________________________________ Email:____________________________________

Where do you prefer to receive calls? (Circle as many as apply) Home Work Cell

In the event of an emergency, whom should we contact?

Name__________________________ Relationship_____________________ Phone #________________________

How did you hear about us?____

RESPONSIBLE PARTY (minor children or elderly guardianship)

Name:____ Relationship to patient:___________________

SS#:_____________________ DOB: ___________________ Driver License#: _______________________

Address:____

City:____ State/Zip:____________________________

Home Phone:____ Cell Phone:___________________________

Work Phone:____ Email:________________________________

INSURANCE INFORMATION

Primary Insurance

Name of Insured:______________________________

Relationship:_________________________________

Insured DOB:_________________________________

SS#:____

Employer:_____________________________________

Employer Address: _____________________________

____

Insurance Company:____________________________

Ins. Co. Address:______________________________

____

Ins. Co. Phone#:_______________________________

Group#:______________________________________

Subscriber ID#:________________________________

Additional Insurance

Name of Insured:______________________________

Relationship:_________________________________

Insured DOB:_________________________________

SS#:____

Employer:_____________________________________

Employer Address:______________________________

____

Insurance Company:____________________________

Ins. Co. Address:______________________________

____

Ins. Co. Phone#:_______________________________

Group#:______________________________________

Subscriber ID#:________________________________

AUTHORIZATION AND RELEASE

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such care to third party payers and/or other healthcare practitioners.
I authorize and request my dental benefit plan to pay directly to the doctor or doctor's group benefits otherwise payable to me.

I understand I am responsible for payment of all services for myself and or my dependent(s). I understand all payments are due when services are rendered unless prior arrangements have been made. I am aware that a 1.5% monthly interest fee will be automatically added to my account if my balance is 21 days or older. I will only receive emergency treatment if my account is not current.

I understand two (2) working days notification is required to change an appointment for myself and my dependent(s). Working days are based on Dr. Burstein's office hours. A broken appointment fee may be charged to my account for missed appointments or last minute cancellations.

Patient's Name (please print) ____

Patient/Parent/Guardian Signature ____ Date_____________________