

PATIENT REGISTRATION

Patient Name _____
Last First Initial

Name you wish to be called _____

Date of Birth ____/____/____ Male ___ Female ___

Social Security # ____/____/____

SOCIAL SECURITY # IS REQUIRED FOR FINANCIAL PURPOSES

Home Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

E-MAIL _____

Home Phone _____

Cell _____

Best time and place to reach you _____

Emergency Contact (not living with you) Name _____

Phone _____ Relationship _____

EMPLOYER INFORMATION

Employer _____

Address _____

City _____ State _____ Zip _____

Occupation _____

Work Phone _____ Ext _____

MARITAL STATUS:

Single ___ Married ___ Divorced ___ Separated ___

Widowed ___ Domestic Partner ___ Minor ___

MARRIED or MINOR

Spouse/Parent Name _____

First Last Initial

Date of Birth ____/____/____

Social Security # ____/____/____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____

How did you hear of our office? _____

Is there someone we may thank for referring you to our office? _____

Today's Date _____

Dental Insurance Information

Insurance Company _____

Insurance Phone _____

Address _____

Employer _____

Employee Name _____

Date of Birth ____/____/____

Subscriber/Policy # _____

Group # _____

Social Security # _____

Dental Insurance 2nd Coverage

Insurance Company _____

Insurance Phone _____

Address _____

Employer _____

Employee Name _____

Date of Birth ____/____/____

Subscriber/Policy # _____

Group # _____

Social Security # _____

Authorization and Release:

I authorize Dr. Jared M. Thompson D.M.D to perform diagnostic procedures, and treatment as necessary for proper dental care.

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

I authorize 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 directly to the dentist, otherwise payable to me.

I understand that my dental care insurance carrier or payor 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 payor. I understand that I am responsible for my child's account.

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

Patient or Guardian's Signature:

X _____ Date _____