welcome

Mr. Mrs. Ms. Miss

LAST FIRST M.I. SEX

Patient's Name: _____

Preferred Name: _____

Address: _____

City: _____

State, Zip Code: _____

Home Phone #: _____

Cell Phone #: _____

Birthdate: _____

Social Security #: _____

Marital Status: _____

E-Mail Address: _____

Employer/School Name: _____

Work Phone #: _____

Drivers License #: _____

Occupation: _____

RESPONSIBLE PARTY INFORMATION

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone #: _____

Work Phone #: _____

Social Security #: _____

Birthdate: _____

Relationship to Patient: _____ Sex: ____

Whom May We Thank For This Referral?

_____

In Case Of Emergency, Contact: _____

Emergency Contact's Phone #: _____

DENTAL INSURANCE FIRST COVERAGE

Policyholder Name: _____

Policyholder Birthdate: _____

Policyholder SS #: _____

Relationship to Patient: _____

Employed By: _____

Employer Phone #: _____

Ins. Co. Name: _____

Ins. Co. Phone #: _____

Policy/Subscriber #: _____ Grp: _____

DENTAL INSURANCE SECOND COVERAGE

Policyholder Name: _____

Policyholder Birthdate: _____

Policyholder SS #: _____

Relationship to Patient: _____

Employed By: _____

Employer Phone #: _____

Ins. Co. Name: _____

Ins. Co. Phone #: _____

Policy/Subscriber #: _____ Grp: _____

PATIENT'S AUTHORIZATIONS

TREATMENT PERMISSION: I authorize the provider(s) to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand if I refuse recommended treatment I will be asked to sigh-off on the proposed service(s) thereby releasing the provider(s) from responsibility.

RELEASE OF INFORMATION: I authorize Waushara Dental Associates, S.C. to release any information, including the diagnosis and the records of any treatment or examination given to me, to third party payors and/or other health practitioners as required.

FINANCIAL AGREEMENT: I understand my dental care insurance carrier or payor of my dental benefits my pay less than the actual bill for services. I understand that I am responsible for payment in full of all costs of my dental care the above named patient receives, including any charges not paid for by my insurance company. I hereby authorize payment of my dental insurance benefits directly to Waushara Dental Associates, S.C.. I certify that all information provided on this form is accurate and correct. I understand I will be responsible for any fees incurred in the process of bad debt collections. I understand that appointments broken or cancelled with less than 24 hours notice may result in a charge.

Patient's/Guardian's Signature _____

Date _____

Revised: 1/08

PATIENT REGISTRATION