

PATIENT REGISTRATION

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____

Street Address _____ City _____ State, Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Birth Date _____ Social Security# _____ e-mail _____

Responsible Party (if someone other than patient) _____

Employer Name & Address _____

Person Guaranteeing Payment on Account _____

Payment is expected when services are rendered

Names, Addresses & telephone numbers of Persons to contact in Case of Emergency:

1st

2nd

How did you become familiar with our office? _____

Will you be using Dental Insurance? Yes ___ No ___

PRIMARY INSURER

SECONDARY INSURER

Name of Insured Person _____

Insured Person SS# _____

Insured Person ID# _____

Insured Person Birth Date _____

Employer Name _____

Insurance Company Name _____

Group/Plan/Policy# _____

Is the Patient a Full Time Student, 19 years or older? Yes ___ No ___

Name and Address of School _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT, REGARDLESS OF INSURANCE COVERAGE.

SIGNED PATIENT, PARENT OR LEGAL GUARDIAN

DATE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE CLAIMS & ALL GROUP INSURANCE BENEFITS PAYABLE DIRECTLY TO WOBURN DENTAL ASSOCIATES.

SIGNED PATIENT, PARENT OR LEGAL GUARDIAN

DATE