# PATIENT REGISTRATION

**PATIENT**

Name_____
LAST FIRST MI

Address _____

City _____State_____ ZIP_____

How long at this address? _____

Home ( )_____Cell ( )_____

Email _____

Social Security # _____ Date of Birth _____

Sex ☐ M ☐ F DL#/State ID#_____

**RESPONSIBLE PARTY** (If same as above, please check here) ☐

Name _____
LAST FIRST MI

Address _____

City _____State_____ ZIP_____

How long at this address? _____

Home ( )_____Work ( )_____

Cell ( )_____ Other ( )_____

Email _____

Social Security # _____DL#_____

Age _____ Date of Birth _____

**EMPLOYMENT**

Occupation _____

Employer _____

How Long at this Employer? _____

Business Address _____

City _____State_____ ZIP_____

Business Phone ( )_____ Ext _____

**EMERGENCY CONTACT INFORMATION**

Name _____
LAST FIRST

Address _____

City _____State_____ ZIP_____

Phone ( )_____Alt. Phone ( )_____

**INSURANCE**

**Primary Insurance Company**

Name _____

Address _____

City _____ State _____ Zip _____

Insurance Co. Phone # _____

Insured's Name _____

Insured's Employer _____

Insured's Soc. Sec. # _____

Date of Birth _____ Group # _____

Member Number _____

**Secondary Insurance Company**

Name _____

Address _____

City _____ State _____ Zip _____

Insurance Co. Phone # _____

Insured's Name _____

Insured's Employer _____

Insured's Soc. Sec. # _____

Date of Birth _____ Group # _____

Member Number _____

1. I understand that the estimated patient portion for treatment will be collected at the time of treatment and that this estimate is based on the information provided by my insurance company. I understand that this is **only** an estimate and that final benefits are not determined until the claim is settled by my insurance company.
2. I understand that I am financially responsible for all charges, whether or not covered or paid for by my insurance company.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I, the undersigned certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Dr. Macaraeg all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of responsible party or patient (Parent if patient is a minor) Date