Welcome to our Practice - Patient Registration

Patient: (Mr., Mrs., Ms., Dr.) First name_____ M.I._____ Last Name_____ Nickname_____ Sex: □ M □ F

Date of Birth_____ Age_____ Social Security #_____ Home Tel #_____ Work Tel #_____

Street_____ City_____ State____ Zip_____ Employer_____

Dentist/Phone #_____ Physician/Phone #_____ Referred By:_____

Have you ever been a patient of our practice? □ Yes □ No

Who will be responsible for your account? □ Self □ Spouse □ Father □ Mother □ Other_____

Name_____ SS#_____ Home Tel #_____ Work Tel #_____

Street_____ City_____ State_____ Zip_____

Employer_____ Address_____ City_____ State_____ Zip_____

Spouse or other guarantor information:

Name_____ SS#_____ Home Tel #_____ Work Tel #_____

Street_____ City_____ State_____ Zip_____

Employer_____ Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

Patient: Student: □ Full Time □ Part Time □ Not
□ Married □ Single □ Divorced □ Separated □ Widow
Employed: □ Full Time □ Part Time □ Retired □ Not

School/Address_____

Do you belong to a **PPO** or **HMO**? □ Yes □ No

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Ins. Co. Name_____

Plan_____ ID #_____

Address_____

_____ Phone #_____

Group #_____ Group Name_____

Policy Holder_____ Relation_____

Sex: □ M □ F Date of Birth_____ SS #_____

Address_____

PRIMARY MEDICAL INSURANCE COMPANY

Employer_____

Ins. Co Name_____

Plan_____ ID #_____

Address_____

_____ Phone #_____

Group #_____ Group Name_____

Policy Holder_____ Relation_____

Sex: □ M □ F Date of Birth_____ SS#_____

Address_____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____

Ins. Co. Name_____

Plan_____ ID #_____

Address_____

_____ Phone #_____

Group #_____ Group Name_____

Policy Holder_____ Relation_____

Sex: □ M □ F Date of Birth_____ SS #_____

Address_____

SECONDARY MEDICAL INSURANCE COMPANY

Employer_____

Ins. Co. Name_____

Plan_____ ID #_____

Address_____

_____ Phone #_____

Group #_____ Group Name_____

Policy Holder_____ Relation_____

Sex: □ M □ F Date of Birth_____ SS #_____

Address_____

OFFICE POLICY

We make every effort to keep down the cost of your surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is **your responsibility** to pay any deductible amount, co-insurance or any other balance not paid for you by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to **Rolin S. Henry, DDS, PC** of the benefits otherwise payable to me.

Signature:_____ Date:_____