PATIENT REGISTRATION

Name: _____ Date of Birth:_____/_____/_____

Gender: M / F Marital Status: Married / Single / Other:_____ Social Security #:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____ Cell Phone:_____

Home Phone: _____Work Phone:_____

How do you preferred to be contacted? Home phone / Cell phone /Work phone/ Email / other:_____

Are you ok with accepting text or email confirmations for our office? Yes / No

Other family members seen here:_____

How did you hear about us? Internet/ Insurance Co / Drive By/ Mailer / Friend or Relative:_____

INSURANCE INFORMATION

☐ **I DO NOT HAVE INSURANCE**

Primary Insurance-

Policy Holders Name: _____Date of Birth:_____/_____/_____

Employer: _____ Relationship to Patient:_____

Insurance co. Name and Address:_____

Group#:_____ ID#:_____ Phone#:_____

Secondary Insurance-

Policy Holders Name: _____Date of Birth:_____/_____/_____

Employer: _____ Relationship to patient:_____

Insurance co. Name and Address:_____

Group#:_____ ID#:_____ Phone#:_____

I authorize my insurance company to pay Blakeslee Dental all insurance benefits otherwise payable to me for service rendered. I authorize Blakeslee Dental to release all information necessary to secure the payment of dental insurance benefits. I authorize the use of this signature on all submissions.

I understand that I am financially responsible for all dental services regardless if insurance is involved. I understand that payment is expected at the time of service. In the event that I comply with my financial obligations, I agree to pay all costs. 8% interest will be applied on unpaid balance and court fess, for collecting unpaid overdue accounts

Signature:_____ Date: _____