

MEDICAL ALERT \_\_\_\_\_

PATIENT REGISTRATION (Please Print)

PATIENT \_\_\_\_\_  
First Name Last Name Middle Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City State Zip Code Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: Male Female Soc. Sec. # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: Single Married Widowed Separated Divorced If married, please answer the following:

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (Not living at same address)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL, **IF NOT PATIENT**

Name \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Patient's relationship to person responsible for bill: Spouse Child Dependent

INSURANCE INFORMATION

Do you have Dental Insurance? Yes No

If you circled Yes, please answer the following questions:

Subscriber's Name \_\_\_\_\_  
(Name of Insurance Policy Holder)

Subscriber's Birthdate \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Group # \_\_\_\_\_

I.D. # \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Patient's relationship to subscriber: Self Spouse Child

ADDITIONAL INSURANCE

Do you have additional Dental Insurance? Yes No

If you circled Yes, please answer the following questions:

Subscriber's Name \_\_\_\_\_  
(Name of Insurance Policy Holder)

Subscriber's Birthdate: \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Group # \_\_\_\_\_

I.D. # \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Patient's relationship to subscriber: Self Spouse Child

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

**SIGNED:** \_\_\_\_\_

