

PATIENT REGISTRATION

Male Female Single

Patient's name _____ Birth Date _____ Widowed

Name of spouse _____ Birth Date _____ Married

If a minor, parent's name _____ Birth Date _____ Divorced

Patient's _____ Separated

Street address _____ Phone (____) _____

City _____ State _____ Zip _____

E-Mail _____ FAX _____ Cell Phone (____) _____

Patient employed by _____ Phone (____) _____ Ext. _____

Business address _____ (Hrs) From: _____ To: _____

Present Position _____ How long held _____

Parent/spouse employed by _____ Phone (____) _____ Ext. _____

Business address _____ (Hrs) From: _____ To: _____

Present Position _____ How long held _____

RESPONSIBLE PARTY

In case of emergency, who should be notified _____ Phone (____) _____

Person responsible for this account _____

Patient's

Social Security number _____ Dential / Health Families

Driver's License number _____ Are you assigned to another dentist? Yes No

If yes, has authorization for treatment

Parent/spouse's Social Security number _____ been obtained from that office? Yes No

Initials: _____

Parent/spouse's Driver's License number _____

INSURANCE INFORMATION

Name of Insured (if different from Patient) _____ Relationship: _____

Name of Insurance Company _____

Address _____

Phone (____) _____

If Parent/spouse has insurance, name of insured _____

Name of Insurance Company _____

Address _____

Phone (____) _____

Whom may we thank for referring you _____

1.I here by certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason. _____ Initials

2.By signing below, I understand that you may verify and exchange information on me and my additional applicants, including requiring reports from credit reporting agencies. _____ Initials

3.I here by authorize payment directly to Harish Hegde, D.D.S. 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. _____ Initials