# DENTAL FITNESS, INC.
# DR. EDITH OAMIL-PACHO

## REGISTRATION FORM

WELCOME! Thank you for choosing our practice and we are so excited to begin our partnership in achieving your dental health goal! To ensure we have the information we need to best serve you, please take a few moments to fill out the form below. If you have any questions, please feel free to contact us by phone or e-mail at any time. Again Thank you for choosing Dental Fitness, Inc.

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

### PATIENT INFORMATION

Last name: _____ First: _____ Middle: _____

Nickname: _____ Address: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Cell Phone No: _____ Home phone no.: _____ E-mail: _____

Preferred method of contact: ☐ Cell phone ☐ home phone ☐ E-mail

Social Security No.: _____ Birth Date: _____ Age _____ Sex _____

If patient is a student, name of school or college attending School/College _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Has any member of your family been treated in our practice? ☐ YES ☐ NO

Who may we thank for referring you? _____

### PERSON RESPONSIBLE FOR THIS ACCOUNT

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other

If other please explain _____

Please check if the information is the same as above ☐

Last Name: _____ First Name: _____ Middle Name: _____

Address Street: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____ Birthday: _____ Sex: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

## DENTAL INSURANCE INFORMATION

| Primary Insurance | | Secondary Insurance | |
|---|---|---|---|
| Insurance Company | | Insurance Company | |
| Policy No.: | | Policy No.: | |
| Employer | | Employer | |
| Employer Tel. No.: | | Employer Tel. No.: | |
| Subscriber Last Name: | | Subscriber Last Name: | |
| First Name | | First Name: | |
| Middle Name: | | Middle Name: | |
| Social Security No.: | | Social Security No.: | |
| Birthday: | | Birthday: | |
| Sex: | ☐ Male ☐ Female | Sex: | ☐ Male ☐ Female |
| Relationship to Patient | | Relationship to Patient | |

Do you have third (3rd) insurance coverage? ☐ YES ☐ NO

If yes please provide third (3rd) insurance information below:

Insurance Company: Policy no.: Employer:

Person to contact in case of emergency: Name: Tel. no.:

Note: Please present all insurance cards or forms to the front desk. It is not the responsibility of this office to obtain your insurance information. Failure to present the correct informations will require full payment for services rendered by the patient.

I hereby grant permission to Dr. Edith Oamil-Pacho to perform all procedures and diagnostic tests which she deems necessary. Initial

If patient is a minor, I as a parent/legal guardian, understand that it is necessary for me to be present while my child is under treatment. I give consent to dentist to perform any necessary dental treatment to my child whether I am present or not in the clinic. Initial

I authorize the release of medical and dental information necessary to process claims for benefits. **I understand that I am responsible for ALL costs of treatment regardless of coverage.** If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses. I authorize payments of benefits directly to Dr. Edith Oamil-Pacho or Dental Fitness, Inc. for services provided. Initial

Less than **48 hours** notice for any cancelation or missed appointment could result in a missed appointment fee (excluding Sundays and Holidays). Initial

**Please signify your acceptance by entering the information requested in the fields below. By my e-Signature or signature below, I certify that I have read, fully understand and accept all terms of the foregoing statement.**

Patient signature: Date :

Parent /guardian signature: Date:

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