Patient Registration Information

Date ____________________

First Name ________________ Last Name _________________ Middle initial _____
Home Address ____
City, State, Zip code ______________________________________
Birth Date _______________ Soc. Sec.__________________

Home phone number_____________________
mobile______________________
email _____________________________
Work phone___________________
Preferred method of contact ___________________

Employer_____________________ Occupation______________________
Business Address________________________________
City, State, Zip code_____________________________________

Referred by ____

Responsible Party (if someone other than patient)

First Name ________________ Last Name _________________ Middle initial _____
Home Address ____
City, State, Zip code ______________________________________
Birth Date _______________ Soc. Sec.__________________

Home phone number______________ mobile________________ email ______________
Work phone___________________

Insurance Information

Name of Insured________________________ Date of Birth_______________
SS#_____________________ Relationship to patient_____________________
Employer_____________________ work phone #_________________________
Address of Employer____
City, state, zip _______________________________________
Insurance Company_________________________________ Group #__________________
Insurance Company Address__________________________________
City, state, zip____
Insurance Company Phone Number__________________________

Additional Insurance
Name of Insured________________________ Date of Birth______________
SS#_____________________ Relationship to patient_____________________
Employer_____________________ work phone #_________________________
Address of Employer____
City, state, zip _______________________________________
Insurance Company_________________________________ Group #__________________
Insurance Company Address__________________________________
City, state, zip____
Insurance Company Phone Number__________________________

Authorization, Release, and Agreement to Pay For Services Rendered.

I authorize Bridgetown Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health care practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual fees for service. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X____________________________________ Date__________________
Signature of patient, or parent if a minor