PATIENT REGISTRATION

Patient Information:

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

Preferred Name:_____Gender: ○ Female ○ Male Birth Date:_____

Marital Status: ○ Married ○ Single ○ Other_____

Address:_____

City_____ State: _____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

EMPLOYER:_____ Occupation:_____

E-mail:_____Spouse Name:_____ Birthdate:_____

I would like to receive confirmation messages: _____Phone Call _____ Text Message _____ E-mail

Patient is: □ Responsible Party □ Policy Holder □ Neither- Dependent/Spouse

How did you hear about Giebenhain Dental? □ Insurance □ Our Website □ Internet Search

□ Friend or Relative -whom may we thank? _____ □ Other_____

Responsible Party: (if someone other than the patient)_____

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

Birth Date:_____ Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Dental Insurance Information:_____

Insurance Company:_____ Employer:_____

Insured Name:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Carrier ID/Group #: _____ Employee ID:_____

Insured Social Security #: _____ Insured Birth Date:_____

Secondary Insurance Information:

Insurance Company:_____ Employer:_____

Insured Name:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Carrier ID/Group #:: _____ Employee ID:_____

Insured Social Security #:_____ Insured Birth Date:_____

I understand that any charges incurred during my dental treatment are my responsibility. Any agreement or contract I have with any insurance company is between that company and myself, and not Giebenhain Dental Associates, P.A. I understand payment for services are expected at time of service unless other arrangements have been made. I also understand that an interest charge of .67% monthly or 8% annually will be assessed to all accounts over 30 days.

Signature of Patient, Parent or Guardian: _____ Date:_____