CHEHALEM DENTAL

Name: _____ **PATIENT REGISTRATION FORM**

Birthdate: _____

We comply with the Health Insurance Portability and Accountability Act (HIPAA) which protects your information. Social security and driver license numbers are required from patients who are paying with a check or not paying at time of service. If paying in full at the time of service with cash or credit we will not require this information.

Home phone: _____ Work phone: _____ Cell phone: _____

Can we leave a message on your home or cell phone? ☐ Home ☐ Cell Can we text you? ☐ Yes ☐ No

I am: ☐ Male ☐ Female I am: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social security number: _____ Driver license number: _____

Mailing address: _____ City/State/Zip: _____

Physical address: _____ City/State/Zip: _____

Email address: _____

Employer: _____ Your occupation: _____

Spouses name: _____ Spouses phone number: _____

Spouses employer: _____ Spouses cell phone: _____

Emergency contact name: _____ Emergency contact phone: _____

Who referred you to our office: _____

RESPONSIBLE PARTY (if the person responsible for paying for this account is not the patient):

Name: _____ Relationship to patient: _____

Social security number: _____ Driver license number: _____

Date of birth: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Mailing address: _____ City/State/Zip: _____

Physical address: _____ City/State/Zip: _____

Email address: _____

DENTAL INSURANCE:

Name of insured: _____ Date of birth: _____

Insurance company: _____ ID number: _____

Group/policy number: _____Ins. Company phone number: _____

Employer: _____City/State/Zip: _____

Employer phone number: _____

* Please let us know if you have secondary insurance

Consent for treatment:

I authorize the dentist and staff to perform any necessary services needed during diagnosis and treatment. I authorize assignment o my insurance benefits directly to the provider for services rendered. I fully understand that I am solely responsible for all charges, including any balance not paid by my insurance company.

Patient / Guardian Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

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