GROVE PARK DENTAL - REGISTRATION FORM

(please print)

PATIENT INFORMATION

NAME [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss

(first) _____ (MI) ____ (last) _____

MARITAL STATUS [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed **SEX** [ ] male [ ] female

DOB _____/_____/_____ **AGE** _____ **SOCIAL SECURITY NUMBER** _____

ADDRESS (street) _____ (city) _____ (state) _____ (zip) _____

PHONE NUMBERS (home) _____ (cell) _____ (work) _____

EMAIL _____

OCCUPATION _____ **EMPLOYER** _____

REFERRAL SOURCE [ ] Dr._____ [ ] family/friend_____ [ ] insurance

[ ] website [ ] phonebook [ ] close to home/work [ ] advertisement [ ] other_____

PERSON RESPONSIBLE FOR BILL _____

OTHER FAMILY MEMBERS SEEN HERE _____

DENTAL INSURANCE INFORMATION (if you do not have dental insurance, please skip)

SUBSCRIBER INFORMATION (if other than patient)

NAME _____ **DOB** ___/___/_____ **SSN** _____

OCCUPATION _____ **EMPLOYER** _____

RELATIONSHIP TO PATIENT [ ] self [ ] spouse [ ] child [ ] other _____

INSURANCE PROVIDER _____ **MEMBER ID** _____ **GROUP ID** _____

FOR VERIFICATION, PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK.

EMERGENCY CONTACT

NAME OF FRIEND OR RELATIVE (not living at same address) _____

REALTIONSHIP TO PATIENT _____ **PHONE NUMBER** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Grove Park Dental or the insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PRINT NAME (if other than patient) _____