Patient Registration

PATIENT INFORMATION (PLEASE PRESS DOWN FIRMLY WHEN PRINTING CLEARLY): Date: ________________, 20 ________

Name ____
Last First Middle Initial

Street Address ______________________________ DOB ____________ Age _________ ____________

City / State / Zip Code ______________________________ M / F Occupation ______________________

Cell # (____) ____________________ Work # (_____) ______________________ Home # (_____) ____________________

Email ______________________________ SSN # (last 4 digits)______________________________

Which would you prefer for notices: (circle one): email / US mail

Employer Name ______________________________ Title ______________________ Work # (____) ____________

Work Address ____
Street Address Apt / Space # City State Zip Code

Emergency Contact Person:____ Phone Number: ______________________

Spouse / parent / guardian name ______________________________ Relationship ______________________________

Cell Phone: ______________________________ Other Phone: ( ) ______________________

(if spouse - a phone number other than home) The phone number(s) listed can be used to contact you for other than dental purposes

INCOMPLETE INSURANCE INFORMATION MAY RESULT IN CLAIM DENIAL BY THE PAYER!

PRIMARY DENTAL INSURANCE COMPANY:

Person Responsible
for Payment: ______________________________

SECONDARY DENTAL INSURANCE COMPANY:

Person Responsible
for Payment: ______________________________

Person Responsible for Payment: Please remember that insurance is considered a method of reimbursing fees paid and is not a substitute for payment. Some insurance companies pay a fixed dollar amount while others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your dental insurance carrier.

Note: A copy of your insurance plan information will be kept in your dental health record.

Who is your Primary Care doctor? ______________________________

Address/Phone number for Primary Care doctor ____

Primary Language: ______________________________

CONSENT AND ASSIGNMENT:

_____Initial - Consent to Treat: I hereby request and authorize Western University of Health Sciences to provide and perform such dental/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial for my health and well-being. It is understood that this consent is given in advance of any specific service, but is given in order that Western University of Health Sciences may exercise their best judgment as to proper medical care, which may be necessary to protect my life and health.

_____Initial - Assignment of Benefits: I hereby assign directly to the Western University of Health Sciences all dental benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature: ____ DATE: ______________________

(IF THE PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENTS)

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO OUR STAFF

NOTE: Please notify us if any of the above information changes during the course of your treatment.

INSTRUCTIONS ON HOW TO CONTACT PATIENT

Patient Name: ______________________________ **Date of Birth:** ____________________

One of our goals is to protect your rights to privacy; therefore, unless we have your permission, information will not be given to anyone regarding you or your finances.

	Yes	No
May we call you at work?		
May we call you at home?		
If no to both questions above, do you have an alternative number, e.g., cell phone we can contact you at? If yes, what is that number?		
May we leave messages (including appointment information) on your answering machine/voice mail?		
May we send you a fax? If so, what is the phone number?		
May we send you an email? If so, what email address should we use?		

We will only provide information about you to those listed below:

Name: ____________________________ Phone: ____________________

Name: ____________________________ Phone: ____________________

Name: ____________________________ Phone: ____________________

____ ______________________________

Patient/Guarantor Signature Date

Note: This consent is valid until otherwise notified in writing.

Note: A photocopy or electronic scan of this document shall be as valid as an original