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PATIENT REGISTRATION

*Welcome to our office! In order to accurately maintain your financial records, please complete both sides of this form.
 All information is completely confidential.*

Patient Information

Date _____

NAME				AGE		Male <input type="checkbox"/>		Female <input type="checkbox"/>		
ADDRESS					SOCIAL SECURITY NUMBER					
CITY			STATE	ZIP	HOME PHONE		WORK PHONE			
DATE OF BIRTH		DRIVER'S LICENSE NUMBER			Married <input type="checkbox"/>		Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>	
<i>If this appointment is for your child, complete the following:</i>										
NAME				DATE OF BIRTH		AGE		Male <input type="checkbox"/>		Female <input type="checkbox"/>
ADDRESS							HOME PHONE			
CITY			STATE	ZIP	SCHOOL			GRADE		

Insurance Information

<i>Primary Carrier:</i>									
INSURANCE COMPANY				EMPLOYEE				DATE OF BIRTH	
SOCIAL SECURITY NUMBER			GROUP NUMBER				DATE EMPLOYED		
<i>Secondary Carrier:</i>									
INSURANCE COMPANY				EMPLOYEE				DATE OF BIRTH	
SOCIAL SECURITY NUMBER			GROUP NUMBER				DATE EMPLOYED		

Account Information

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT					RELATIONSHIP TO PATIENT				
ADDRESS (IF DIFFERENT THAN PATIENT)							PHONE		
EMPLOYER			BUSINESS PHONE		BUSINESS ADDRESS				

Emergency Contact

Is another member of your family or a relative a patient at our office? YES <input type="checkbox"/> NO <input type="checkbox"/>						THEIR NAME			
PERSON TO CONTACT IN CASE OF EMERGENCY							PHONE		
ADDRESS				CITY		STATE		ZIP	

Referred By

So that we can thank them, who referred you to our office?									
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I understand responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% finance charge (18 annual percentage rate) may be added to my account.

X _____
 PATIENT SIGNATURE

 DATE

X _____
 PARENT/RESPONSIBLE PARTY SIGNATURE

 DATE

**AUTHORIZATION FOR SUBMISSION OF CLAIMS AND
 ASSIGNMENT OF BENEFITS**

PATIENT NAME _____
LAST FIRST INITIAL

I authorize the office of **BOGROW & ASSOCIATES** to submit claims for payment for services to the health care service plans or insurance companies name below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance benefits.

1. _____
INSURANCE COMPANY
2. _____
INSURANCE COMPANY
3. _____
INSURANCE COMPANY

NAME (PATIENT, PARENT OR GUARDIAN)

X _____
SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____
LAST FIRST INITIAL

I authorize the office of **BOGROW & ASSOCIATES** to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

NAME (PATIENT, PARENT OR GUARDIAN)

X _____
SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

Signature is valid for _____ years from the above date, unless revoked by me at an earlier date.