Dental Registration

Patient Information

Date_____

Patient Name_____
Last name First name Middle Initial

Nickname_____

Mailing Address_____

City_____ State_____ Zip_____

Physical Address _____

SS#_____

Email Address: _____

Sex ☐M ☐F DOB_____ Age_____

☐Married ☐Single

Occupation_____

Employer_____

Spouse's name_____

Whom may we thank for referring you?

_____

How do you intend to pay? ☐Cash ☐Check ☐Credit Card

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party:_____

Birthdate of responsible party:_____

Mailing address_____

City_____State_____Zip_____

Relationship to patient_____

SS#_____ Phone:_____

Dental Insurance

Primary Subscriber_____

Birthdate_____SS #_____

Phone #_____

Relationship to Patient_____

Insurance Co._____

Group #_____ID #_____

Employer_____

Is Patient covered by additional Insurance? Y/N

Secondary Subscriber_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____ID #_____

Employer_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company and assign directly to Elisha Mayes, DDS, PC (DBA Eli Mayes Dental & Elgin Family Dental) all insurance 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 insurance. I authorize the use of my signature on all insurance submissions. The above-named dental business may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Parent/Guardian

_____

Printed name_____

Date_____Relationship to Patient_____

PHONE NUMBERS

Home (___)_____ Work (___)_____ Cell (___)_____ Spouse (___)_____

Best Time & Place to reach you_____ May we Text you? Yes ___ No ___

In case of Emergency, Contact (someone not living in household)

Name & relationship_____ Phone (___)_____

AUTHORIZATION FOR TREATMENT

I authorize my treatment or treatment of _____. I agree to pay all fees and charges for such treatment the day they are incurred. All proceeds of insurance are assigned to the Doctor where applicable, but without the Doctor assuming responsibility for the collection of those claims.

Patients Signature_____Date_____

Parent/Responsible Party Signature_____Relationship to patient_____