AESTHETIC DENTAL — PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth _____/_____/_____

How would you like to be addressed? _____ Marital Status (Single) (Married) (Divorced) (Widow) Sex (M) (F)

Address _____City _____ State _____ Zip _____

Home Phone # _____ Work Phone #_____ Mobile Phone # _____

Social Security # _____ Email Address _____

Student: ___ Yes ___ No School _____

Employer _____ Occupation _____

Employer Address _____ Employer Phone # _____

In case of emergency contact: Name _____ Phone # _____

How Did You Hear About Us?

__ Flyer/AD __ Insurance Plan Referral __ Sign/Bldg. Location __ Marketing Representative

__ Yellow Pages __ Employer __ Other DDS Referral __ Family/Friend __ Website

__ Community Event _____ __ School _____ __ Other _____

INSURANCE INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill? _____ Mobile Phone # _____

Employer _____ Occupation _____

Employer Address _____ Employer Phone # _____

Name of Primary Insurance Co. _____ Group # _____ Policy #_____

Subscriber's Name: _____ Social Security # _____

Subscriber's Date of Birth _____/_____/_____ Patient's relationship to subscriber? __ Self __Spouse __ Child __Other

Name of Secondary Insurance Co. _____ Group # _____ Policy #_____

Subscriber's Name: _____ Social Security # _____

Subscriber's Date of Birth _____/_____/_____ Patient's relationship to subscriber? __ Self __Spouse __ Child __Other

AUTHORIZATION AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I may only be given an estimate and that I am financially responsible for any balance due after insurance payments. I also authorize Aesthetic Dental Spa or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date