Colliver | Dental Group

REGISTRATION FORM

Today's Date:		PCP:			
PATIENT INFORMATION					
Patient's last name: First:		Middle:	Marital status:		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Phone no.:	Email:			
Occupation:	Employer:	Employer phone no.:			
How did you hear about our office? Preferred pharmacy: Preferred doctor: Preferred hygienist:					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Phone No.:		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.					
Patient/Guardian signature		Date			


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