Patient Registration and Medical History

Date_____ Home Phone _____

Patient_____ Preferred Name _____

Address_____City_____State_____Zip _____

Email_____ Cell Phone _____

Sex___M ____F Age_____Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Divorced

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Spouse/Parent Name _____ Business Phone _____

Emergency Information:

Emergency Contact Name: _____ Phone Number:_____

How did you hear about our office?_____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

Insured's name _____

DOB_____ SS#_____

Insured's employer_____

Insurance Co._____

Ins. Co.Address _____

Phone #_____

ID# _____ Group#_____

If you have a dual insurance coverage, complete this for the second coverage (Secondary Carrier)

Insured's name_____

DOB_____ SS# _____

Insured's employer_____

Insurance Co._____

Ins. Co. Address_____

Phone # _____

ID# _____Group# _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Assignment and Release

I, the undersigned, have insurance with _____and assign directly to Drs. Hutchison, Gorman, Eun, and Guanci, all 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 this signature on all my insurance submissions whether manual or electronic.

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Date_____ Signature of Insured/Guardian_____