USE BLACK OR BLUE INK ONLY

PATIENT REGISTRATION

Clear Form | Print

SECTION 1: PATIENT DATA

Last Name laizzo First Name Felicia MI test

☐ Male ☐ Female ☐ Single ☐ Married Name of Spouse test

Address 2298 Major Mackenzie Dr. City Maple State ON Zip L6a1m9

Patient's Home Phone 647-525-9873 Patient's Work Phone 905-265-9000 Cell Phone

Name of Patient's Employer or School if Student test Patient's Date of Birth test

Patient's Social Security No. test Driver's License No. test E-Mail test

Who referred you to our office? Yellow Pages __ , Internet __ , Friend test (Name) , Other test (Source)

In case of emergency who should be notified test Phone # test

Secondary Contact: test Phone # test Relationship test

SECTION 2: RESPONSIBLE PARTY INFORMATION (If you are not the patient)

Last Name test First Name test MI Title ☑ Mr. ☑ Mrs. ☑ Ms

Address test City test State test Zip test

Responsible Party's Home Ph test Work test Cell test

Name of Responsible Party's Employer test

Responsible Party's Birth Date test Social Security Number test Driver's License Number test

SECTION 3: PRIMARY INSURANCE INFORMATION:

Name of Insured tst Relationship to Patient test

Birth Date of Insured test Social Security Number of Insured test

Employer's Name test Address test

Insurance Company test Group Number test

Address test City test State test Zip test

SECTION 4: SECONDARY INSURANCE INFORMATION:

Name of Insured test Relationship to Patient test

Birth Date of Insured test Social Security Number of Insured test

Employer's Name test Address test

Insurance Company test Group Number test

Address test City test State test Zip test

SECTION 5: AUTHORIZATION AND RELEASE:

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Parent if Minor _____ Date _____

SECTION 6: FINANCIAL RESPONSIBILITY:

I understand that dental insurance is a contract between myself and my insurance company. I further understand and agree that I am financially responsible for all charges whether or not paid by insurance. I also understand that if collection procedures become necessary, I am responsible for any and all legal charges incurred by the dentist to collect charges due by me.

Signature of Responsible Party _____ Date _____