

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION:

Date \_\_\_\_\_

Patient: \_\_\_\_\_  
Last First MI Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F Single-Married-Widowed-Separated-Divorced

Patient S.S# \_\_\_\_\_

Employed By: \_\_\_\_\_ Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## SPOUSE/PARENT INFORMATION:

Name: \_\_\_\_\_  
Last First MI Birth Date \_\_\_\_\_

Employed By: \_\_\_\_\_ Address \_\_\_\_\_

Business Phone# \_\_\_\_\_ Ext: \_\_\_\_\_

## INSURANCE INFORMATION:

### Primary Insurance Coverage:

Name of Insured: \_\_\_\_\_ Relationship to Patient: Self / Spouse / Dependent

S.S# of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Dental Insurance Co.: \_\_\_\_\_ Group # \_\_\_\_\_  
BRING INSURANCE CARD TO FRONT DESK

### Secondary Insurance Coverage:

Name of Insured: \_\_\_\_\_ Relationship to patient: Self / Spouse / Dependent

S.S# of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Dental Insurance Co.: \_\_\_\_\_ Group # \_\_\_\_\_  
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## FINANCIAL AGREEMENT:

I acknowledge that payment or insurance co-payment (if applicable) is due at the time of treatment unless other specific arrangements are made. I agree that I am solely responsible for all fees for services provided. I accept full financial responsibility for all charges not covered by insurance. I will make timely/reasonable payments to clear any monies owed as designated by Dr. Gordon's practice. I agree to clear overdue balances within 120 days unless other arrangements are authorized by Dr. Gordon's office.

In order for the office to contain increasing administration costs, a 1.50% per month service charge (18% per annum) will be charged on all account balances outstanding beyond 60 days.

I have read, understand, and accept the above financial agreement:

X \_\_\_\_\_  
SIGNATURE OF PATIENT/ PARENT DATE(TURN OVER AND COMPLETE OTHER SIDE)

