PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: __________________ MI____ Last Name: __________________ Preferred Name: _________________

Date of Birth: __________ Social Security#: _________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Gender: ☐ Male ☐ Female

Home address: ____________________________________ City/State/ZIP: _________________________________

Home Phone: _________________ Cell Phone: _________________ Email: _________________________________

Employer: ______________________________ Work Phone: ___________________

Emergency Contact Name: _____________________________ Emergency Contact #: ________________________

GUARANTOR INFORMATION: (If other than patient, list the person or insured name who is responsible for the bill)

First Name: ____________________ MI ____ Last Name: ___________________

Date of Birth: ____________ Social Security #: ______________________________

Relationship of Patient to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Other ___________________

Address: ____ City/State/ZIP: _______________________________

Mobile phone #: _________________________

Employer Name and Address ____

Work phone # ____________________________

INSURANCE INFORMATION: (Please provide your insurance card for our records)

PRIMARY INSURANCE

Plan Name: ____________________________ Insured Name: _______________________

Insured Social security #: ___________________ Insured DOB: ________________________

Policy/ID #: __________________ Group #___________________ Effective Date: ______________

Claims Address & Phone: ____

SECONDARY INSURANCE (if applicable)

Plan Name: ____________________________ Insured Name: _______________________

Insured Social security #: ________________ Insured DOB: ________________________

Policy/ID #: __________________ Group #___________________ Effective Date: ______________

Claims Address & Phone: ____

I certify that I am covered by ___________________ Insurance and I assign directly to Dr. Lawler all Insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and any co-payment and deductible on the day of service that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on my insurance submissions, whether manual or electronic. I also understand that I am responsible for payment in full on the day services if I do not have dental coverage.

Responsible Party Signature: _______________________________________ **Date:** ______________________