PATIENT REGISTRATION

NAME ______ DATEOFBIRTH ______ PRESENTAGE ______ S M D W C
LAST FIRST MIDDLE (NICKNAME)

ADDRESS ______ CITY ______ STATE ______ ZIP ______.

HOME PHONE ______ OTHER ______ FAMILY PHYSICIAN ______ **MEDICAL ALERT**

SOC. SEC. NO. ______ OCCUPATION ______ NEAREST RELATIVE ______.

EMPLOYER ______ PHONE ______.

ADDRESS ______ ADDRESS ______.

PERSON RESPONSIBLE FOR ACCOUNT

NAME ______ RELATIONSHIP ______

ADDRESS ______

SOC. SEC. NO. ______ OCCUPATION ______

EMPLOYER ______

ADDRESS ______

INSURANCE INFORMATION

INSURANCE COMPANY ______

NAME OF GROUP DENTAL PROGRAM ______

POLICY NUMBER ______ GROUP NUMBER ______.

UNION LOCAL ______

EFFECTIVE DATE OF INSURANCE ______ TIME LIMIT FOR CLAIMS ______

METHOD OF PAYMENT UCR SCHEDULE OF BENEFITS OTHER ______

CO INSURANCE INSURANCE CO. SHARE ______ PATIENT'S SHARE ______

DEDUCTIBLE YES NO $__________ AMOUNT ______

IF YES, INDIVIDUAL FAMILY ANNUAL LIFETIME ______

COVERAGE

INSURED DEPENDENT'S NAME ______.

SPOUSE ______ BIRTHDATE ______.

OTHER ______.

NAME ______.

RELATIONSHIP ______ BIRTHDATE ______.

SECONDARY COVERAGE

NAME OF SUBSCRIBER ______.

SUBSCRIBER'S S.S. NUMBER ______.

NAME & ADDRESS OF EMPLOYER ______.

DENTAL PLAN NAME ______.

UNION LOCAUGROUP NUMBER ______.

CARRIER NAME & ADDRESS ______.

______.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize the release of all necessary information to Insurance Companies and other payers, and to assign to Dr. Richard J. Sorbera, and/or Dr. Shibly 0. Malouf, authority to claim and collect medical and dental benefits and payments directly on my behalf.

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

______
PATIENT'S SIGNATURE (PARENT IF MINOR) DATE