Sonja Maggard, DMD

Family and Cosmetic Dentistry

REGISTRATION FORM

PATIENT INFORMATION: (Please Print)

Patient Full Name:_____ **Date:** _____

Nickname: _____ **Birthdate:** ____/____/_____ **SS#:** _____
(please provide for insurance/Identification purposes)

Whom may we thank for referring you? _____

Please circle one: Married Divorced Single Widowed **Please circle one:** Male Female

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Cell #: ( )_____-_____ **Home #:** ( )_____-_____ **Work #:** ( ) _____-_____ **Other:**( ) _____-_____

Email Address: _____ **Occupation:** _____

Employer: _____ **Employer Phone:** _____

Employer Address:_____ **City:**_____ **St:** _____ **Zip:** _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name:_____ **Relationship to Patient:** _____

Contact #: _____ **Address:**_____**City:**_____ **St:**____ **Zip:**_____

INSURANCE INFORMATION:

Insurance Company Name: _____ **Phone:** _____

Claims Address:_____ **City:**_____ **St:** _____ **Zip:** _____

Subscriber Name:_____ **Relationship to Patient:** _____
(If other than patient, please complete – if same as patient, write "same as above")

Subscriber SS#:_____ **Subscriber DOB:** ____/____/____ **ID# on card:** _____

Employer/Group Name:_____ **Group #:** _____

Employer Address: _____ **City:**_____ **St:** _____ **Zip:** _____

I verify that the information completed above is accurate and I understand that I am responsible for my account regardless of my insurance. I also understand that my insurance reflects only an agreement between me and my insurance company. Any balance remaining after insurance is the responsibility of the patient or guarantor. I understand that I may be charged a 1.5% finance charge per month for any delinquent balances on the account. I give my permission for the dentist and/or clinical team to take any necessary radiographs, study models and/or photographs in order to make a complete diagnosis of my dental needs. I authorize the dentist to release records as needed to my insurance company or third party to secure payment of benefits. I authorize my dental carrier to send payments directly to the dentist. Lastly, I authorize use of this signature on all insurance submissions.

X_____ **Date:** _____
Patient or Responsible Party Signature

X_____ **Date:** _____
Doctor Signature

PLEASE COMPLETE BOTH SIDES