Patient Registration Form

OSTBY FAMILY DENTAL

E-mail: Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Full Name: Last First Middle Maiden

Date of Birth: Social Security #: Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address: Street City State Zip Code

Home Phone: Cell Phone: Other Contact Phone:

Employer: Phone:

Spouse's Name: Date of Birth: Social Security #:

Spouse's Employer: Phone:

EMERGENCY CONTACT: Home #: Work #:

(THIS MUST BE COMPLETED)

COMPLETE BELOW FOR PATIENT'S UNDER 18 AND/OR COVERED BY ANOTHER'S INSURANCE.

Father's Full Name: Date of Birth: Social Security #:

Address (if different than Child's): Street City State Zip Code

Home Phone: Employer: Phone:

Mother's Full Name: Date of Birth: Social Security #:

Address (if different than Child's): Street City State Zip Code

Home Phone: Employer: Phone:

Insurance Information *COMPLETE ONLY IF YOU DO NOT HAVE A CURRENT COPY OF YOUR INSURANCE CARD.*

Primary Insurance: **Effective Date:**

Member's Name (Policy Holder): Policy Holder's Date of Birth:

Policy Holder's Social Security #: Member ID#:

Group #: Employer:

Secondary Insurance: **Effective Date:**

Member's Name (Policy Holder): Policy Holder's Date of Birth:

Policy Holder's Social Security #: Member ID#:

Group #: Employer:

Insurance Information - Copy of Dental Card

Copy of Dental Card:

Financial Responsibility

Financial, Assignment and Release Agreement:

I, the responsible party, hereby agree to pay all the charges submitted by the course of treatment for the patient. I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient.

Print Responsible Party Name: *Date:*

_____ _____

Signature of Responsible Party: *Date:*

X_____ _____