Fredericksburg Dental Associates

REGISTRATION FORM

Today's Date:	Email address:

PATIENT INFORMATION

Patient's last name:	First:	MI	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance? ○ Yes ○ No	
Occupation:	Employer:	Employer address:	Employer phone no.:

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I have read and understand the HIPPA regulations. I also authorize Fredericksburg Dental Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____