Blockley Dental

Date: _____

PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name: _____ Middle Initial:___ Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder Spouse:_____ Contact # _____

Address: _____ City, State, Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail:_____ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time School: _____

Preferred Dentist:_____ Preferred Hygienist:_____ Preferred Pharmacy:_____

Referred By:_____ Emergency contact:: _____ Phone #: _____

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____ City, State, Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers Lic. #:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security or ID #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:(If Applicable)

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security or ID #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Payment Options: __Cash ___Check __Visa __MasterCard __Discover Outside Credit Options: __Care Credit __ Citi Health Card
(Please check option you prefer)

Late Charge or Missed Appointment: I understand that I may be charged a Late Charge for account balances after 30 days and a fee may also be charged for a broken appointment with less than 24hr notice.

Consent:
I understand that payment is due at the time services are rendered.
I understand that my insurance is an agreement between myself and my insurance company; and that I am responsible for my balance regardless of my insurance. I assign dental insurance benefit payments to be paid directly to Blockley Dental.
I also understand that the parent that brings a minor child is financially responsible for payment, regardless of insurance or personal situation.
The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my(or patients)health. It is my responsibility to inform the dental office of any changes in medical status.

_____Date_____

Signature of Patient or Responsible Party