

Blockley Dental

PATIENT REGISTRATION

Date: _____

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.

Signature of Patient or Responsible Party

Date