

# PATIENT REGISTRATION



**Welcome to our office.** We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

HAYES BARTON DENTISTRY

## 1 - About You

Today's Date: \_\_\_\_\_

Name: Mr. Mrs. Ms. Dr. \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST)

I prefer to be called: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male  Female  Single  Married  Divorced  Widowed

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred method of contact:  Text  Email  Phone Call

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Is another family member or relative a patient in our office? \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## 2 - About Your Spouse

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

## 3 - Account Information

Person Financially Responsible for Account: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ SS #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

## 4 - Emergency Contact

In the event of an emergency, whom should we contact?

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #: \_\_\_\_\_

## 5 - Referral Source

Our practice is fortunate to receive referrals from patients and colleagues who have been pleased with the services that we provide. Whom may we thank for referring you to us? \_\_\_\_\_

## 6 - Dental Insurance

Does your employer provide dental insurance?  Yes  No

Are you eligible for direct reimbursement benefits?  Yes  No

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relation: \_\_\_\_\_

Birth Date of Policy Holder: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Date Employed: \_\_\_\_\_

*The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.*

## 7 - Financial Responsibility

I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest (1.5% per month - 18% per annum), together with any collection costs and attorney fees as may be required to effect collection of this note.

I hereby authorize payment of my dental insurance benefits directly to Hayes Barton Dentistry. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services and I understand that I am financially responsible for payments in full of all accounts by signing this agreement.

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

*Signature of patient, parent, or guardian*

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

*Signature of guarantor of payment/responsible party*