WELCOME
Patient Registration

Date: _____

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: _____
Last First MI

Address: _____
Street Apt. #

_____
City State Zip Code

Home Tel #: _____ Work #: _____ Cell #: _____

Sex: ☐ Female ☐ Male Birth Date: _____ ☐ Married ☐ Single ☐ Child ☐ Other Soc. Sec #: _____

Email: _____ Referred by: _____

Last Dentist: _____ Date of Last Dental Visit:: _____

Emergency Contact: _____

Who will be responsibility for your account? ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Name: _____ SS #: _____ DOB: _____

Address: _____
Street City State Zip Code

Phone #: _____ Cell #: _____

Employer Name and Address: _____

Employer Tel. #: _____ Drivers Lic. #: _____

Insurance Information

Name of Insured: _____ DOB: _____

Insurance Company: _____ Phone: _____

Employer: _____ Emp. Phone# : _____

Emp. Address: _____

ID #: _____ Group #: _____ Patients relationship to insured: ☐Self ☐Spouse ☐Child ☐ Other

Blue Coast DENTAL GROUP

Patient Name:_____

Secondary Insurance Information

Name of Insured: _____ DOB: _____

Insurance Company: _____ Phone: _____

Employer: _____ Emp. Phone# : _____

Emp. Address: _____

ID #: _____ Group #: _____ Patients relationship to insured: ☐Self ☐Spouse ☐Child ☐ Other

Financial Policy

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full at the time of the visit, unless other arrangements have been made with the business manager. If an account is not paid within 90 days of the date of service or financial arrangements have not been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims in compliance with HIPPA standards.

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ _____

Patient (guardian) signature Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices in compliance with HIPPA has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

_____ _____

Patient (guardian) signature Date

FOR OFFICE USE ONLY: