

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME _____ Male Female
Last First M.I.

ADDRESS _____
Street Apt. # City State Zip

AGE _____ BIRTHDATE _____ TELEPHONE _____ / _____
Home Work

PLACE OF EMPLOYMENT (if applicable) _____

SCHOOL (if student) _____

INSURANCE INFORMATION *(if applicable)*

DENTAL INSURANCE CO. _____ GROUP # _____ UNION # _____

ADDRESS OF INSURANCE CO. _____

NAME OF INSURED (if not patient) _____ BIRTHDATE _____

ADDRESS OF INSURED _____

INSURED'S EMPLOYER _____ ADDRESS _____

INSURED'S ID OR SOCIAL SECURITY # _____ DEDUCTIBLE AMOUNT _____

PATIENT'S RELATIONSHIP TO INSURED _____

OTHER DENTAL INSURANCE

DENTAL INSURANCE CO. _____ GROUP # _____ UNION # _____

ADDRESS OF INSURANCE CO. _____

NAME OF INSURED (if not patient) _____ BIRTHDATE _____

ADDRESS OF INSURED _____

INSURED'S EMPLOYER _____ ADDRESS _____

INSURED'S ID OR SOCIAL SECURITY # _____ DEDUCTIBLE AMOUNT _____

PATIENT'S RELATIONSHIP TO INSURED _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME (if other than patient) _____ TELEPHONE _____

ADDRESS _____
Street Apt. # City State Zip

RESPONSIBLE PERSON'S EMPLOYER _____

ADDRESS _____

AUTHORIZATION

I hereby authorize payment directly to Dr. Bergquam's office of the group insurance benefits otherwise payable to me and authorize release of any information relating to dental insurance claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Bergquam and his staff to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the health history are correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Adult Patient Father (or husband) Mother (or wife) Guardian Other