PATIENT REGISTRATION AND INSURANCE INFORMATION

NAME _____ DATE OF BIRTH _____
FIRST MIDDLE LAST

RESIDENCE
ADDRESS _____
STREET CITY STATE ZIP

E-MAIL _____

RESIDENCE PHONE _____ BUSINESS PHONE _____ MAY WE CONTACT YOU AT WORK? _____ YES _____ NO

ADDRESS WHERE STATEMENT SHOULD BE SENT IF DIFFERENT THAN ABOVE.

_____
NAME ADDRESS

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

INSURANCE COVERAGE

CARRIER NO. 1			CARRIER NO. 2 (COMPLETE WHEN COVERED BY TWO COMPANIES)		
(1) NAME OF INSURED (LAST NAME, FIRST NAME, INITIAL)			(1) NAME OF INSURED (LAST NAME, FIRST NAME, INITIAL)		
(2) STREET ADDRESS			(2) STREET ADDRESS		
(3) CITY	(4) STATE	(5) ZIP CODE	(3) CITY	(4) STATE	(5) ZIP CODE
(6) BIRTH DATE OF INSURED	(7) INSURED'S SOCIAL SECURITY NO.		(6) BIRTH DATE OF INSURED	(7) INSURED'S SOCIAL SECURITY NO.	
(8) EMPLOYER	(8a) PHONE		(8) EMPLOYER	(8a) PHONE	
(9) GROUP NO.	(10) UNION NO.		(9) GROUP NO.	(10) UNION NO.	
(11) INSURANCE COMPANY			(11) INSURANCE COMPANY		
(12) STREET ADDRESS			(12) STREET ADDRESS		
(13) CITY	(14) STATE	(15) ZIP CODE	(13) CITY	(14) STATE	(15) ZIP CODE
(16) PHONE			(16) PHONE		

SIGNATURE ON FILE

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY DENTIST TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. THIS FORM ALSO AUTHORIZES THE DENTIST TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF HEALTHCARE OPERATIONS, TREATMENT AND PAYMENT ACTIVITIES. THIS SIGNATURE IS MY ACKNOWLEDGEMENT THAT I HAVE READ THE NOTICE OF PRIVACY POLICIES AND CONSENT FOR THE DENTIST TO USE MY PERSONAL HEALTH INFORMATION FOR THE PURPOSES OF HEALTHCARE OPERATIONS, TREATMENT AND PAYMENT ACTIVITIES.

I _____ HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY AND HEREBY ASSIGN DIRECTLY TO DENTAL HEALTH OF MAPLEWOOD ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED LESS ANY INSURANCE BENEFITS WHEN RECEIVED BY AND PAID TO DENTAL HEALTH OF MAPLEWOOD. AUTHORIZATION IS HEREBY GIVEN TO RELEASE ALL INFORMATION NECESSARY TO THE PAYMENT OF SAID BENEFITS. IN THE EVENT OF A DEFAULT ON PAYMENT, RESPONSIBLE PARTY WILL PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN COLLECTION OF THIS AMOUNT, AND ANY FUTURE OUTSTANDING BALANCES.

_____ _____
AUTHORIZED SIGNATURE 0F COVERED EMPLOYEE/RESPONSIBLE PARTY DATE

_____ _____
SIGNATURE OF SPOUSE, ALSO RESPONSIBLE PARTY DATE

SEE REVERSE SIDE FOR DEPENDENT COVERAGE