Autumn Ridge Dental

Registration Form

(Please Print)

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. First Name: M.I. Last Name

Preferred Name: Former name: Marital status (circle one) Single / Mar / Div / Sep / Wid

Sex: ❑ M ❑ F | Birth date: / / | DL# | Social Security no.: - -

Home Phone no: ( ) - Cell Phone: ( ) - *Email Address*:
Would you like text reminders: (circle one) yes no (fees may incur depending on your coverage) **Email needed for reminders, birthdays & news**

Street address / P.O. Box:

City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( ) -

How did you find out about us? (please check one box): ❑ Doctor ❑ Family/Friend ❑ Website ❑ Yellow Pages ❑ Newspaper ❑ Radio
Name of person who referred you:_____

Other family members seen here:

Name of local friend or relative (***NOT living at same address***): Relationship to patient:

Home phone no.: ( ) - Work phone no.: ( ) - Cell phone no.: ( ) -

PARENT/GUARDIAN INFORMATION (IF SELF, SKIP TO NEXT SECTION)

Name: Birth date: / / Social Security no.: - -

Is this person a patient here? ❑ Yes ❑ No Relationship: ❑ Father ❑ Mother ❑ Legal Guardian | Home phone no.: ( ) -

Address: Cell Phone: ( ) -

Occupation: Employer: Employer phone no. :( ) -

DENTAL INSURANCE INFORMATION

Autumn Ridge Dental is ***OUT OF NETWORK WITH ALL COMMERICAL INSURANCE COMPANIES.***

Primary Dental Insurance Company	Secondary Dental Insurance Company
Employer_____	Employer_____
Business Address_____	Business Address_____
Bus Tel_____ Plan_____	Bus Tel_____ Plan_____
Ins Co Name_____	Ins Co Name_____
Address_____	Address_____
Group#_____Group Name_____	Group#_____Group Name_____
Insured Party:_____Relation:_____	Insured Party:_____Relation:_____
Sex ❑ M ❑ F Birth Date _____ SSN_____	Sex ❑ M ❑ F Birth Date _____ SSN_____
ID#_____	ID#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that I am financially responsible for any balance. I understand that that I will be responsible for any and all fees or cost incurred included legal or attorney fees, necessary to collect for services/charges provided by this office. I also authorize Autumn Ridge Dental or insurance company to release any information required to process my claim and to release any information to secure payment by use of collection agency, court or attorney. In addition I give permission to have my records and/or x-rays shared with my medical physician or other specialist as needed. Autumn Ridge Dental has my permission to obtain medical information that pertains to my dental treatment from my physician(s).

Privacy Policy acknowledged.

*Patient **OR** Parent/Guardian signature*	*Today's Date*

Form edited 12/2016