

Patient Registration Form (please fill out completely)

Date _____

How did you hear about us? _____

Patient Information:

Email address _____

First Name: _____ Initial: _____ Last Name: _____ Preferred Name: _____

(Billing Address: _____ City: _____ State: _____ Zip Code: _____

Home Tel # _____ Cell # _____ Work # _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security Number: _____ College Student (Full time) School Name: _____

Emergency Contact: _____
(Name) (Relation) (Phone #)

Responsible Party Information: (Must be completed if different from patient information)

Last Name: _____ First Name and M.I.: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

(Billing Address: _____ City: _____ State: _____ Zip Code: _____

Home Tel # _____ Cell # _____ Work # _____

Dental Insurance Information:

1. Primary

Dental Insurance Company Name: _____ Employer: _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____ Date of Birth: _____ Social Security Number: _____

Group #: _____ Union or Local #: _____

2. Secondary

Dental Insurance Company Name: _____ Employer: _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____ Date of Birth: _____ Social Security Number: _____

Group #: _____ Union or Local #: _____

Patient/Guarantor Signature for Assignment of Benefits & Records Release:

I hereby assign transfer and authorize payment directly to Buffalo Dental Group any and all rights, title, interest or medical reimbursement benefits under my insurance policy. I authorize release of any medical information needed to determine these benefits or required for medical care. This authorization shall remain valid until I give written notice revoking said authorization.

_____ I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan.

_____ I understand that all financial obligations are due in full on the day treatment is rendered if I am not covered by an insurance carrier.

Patient Signature: _____ **Date:** _____