J BREWSTER BEDE, DDS, PS, DAVID W. BRANCH, DDS, CASEY E. CARMODY, DDS
PATIENT REGISTRATION

PATIENT _____ _____ ____ TODAY'S DATE_____
First Name Last Name Middle Initial

Address_____

_____ _____ _____
City State Zip

Cell Phone _____ ☐ I would like to receive text message correspondences

Email _____ ☐ I would like to receive email correspondences

Work Phone _____ Home Phone_____

Date of Birth _____ Gender: ☐Male ☐Female

Social Security #_____ Employer _____

Spouse's Name_____ Employer_____ Phone_____

Who referred you to our office?_____

IN CASE OF EMERGENCY:

Name_____ Relationship to Patient_____

Phone number(s):_____ _____ _____
Primary Secondary Other

PERSON RESPONSIBLE FOR BILL, <u>IF NOT PATIENT</u>

Name_____ Employer_____

Mailing Address_____

Cell phone_____ Work Phone_____

Patient's relationship to person responsible for bill _____

Primary Insurance Information:

Name of Insured_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Subscriber ID_____ Insured Social Security #_____

Insured Birth date_____ Employer_____

Insurance Company_____ Group number _____

Secondary Insurance Information:

Name of Insured_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Subscriber ID_____ Insured Social Security#_____

Insured Birth date_____ Employer_____

Insurance Company_____ Group number _____

ASSIGNMENT AND RELEASE: I HEARBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE DENTIST. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I ALSO AUTHORIZE THE DENTIST OR INSURANCE COMPANY TO RELEASE ANY INFORMATION FOR THIS CLAIM.

Signature _____ Date_____

Please print, sign, and bring this form to your first appointment.