PATIENT REGISTRATION

(PLEASE PRINT)

Patient Information

Name_____ Soc. Sec. #_____
Last First Initial

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ e-mail_____

Sex ☐ M ☐ F Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient (or responsible party) Employed by_____ Business Phone_____

Business Address _____ City_____ State_____ Zip_____

Spouse/Parent/Guardian Name _____ Employer _____

Spouse/Parent/Guardian Soc. Sec. # _____ How did you hear about us? _____

Nearest adult not living with you _____
name address phone

Primary Dental Insurance Information

Subscriber Name _____ Soc. Sec. # _____
Last First Initial

Address_____ City_____ State_____ Zip_____
(if different from patient's)

Subscriber Birthdate_____ Subscriber Home Phone _____ Subscriber Cell Phone_____

Subscriber Employed by_____Business Phone_____

Business Address_____ City_____ State_____ Zip_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Secondary Dental Insurance Information

Subscriber Name _____ Soc. Sec. # _____
Last First Initial

Address_____ City_____ State_____ Zip_____
(if different from patient's)

Subscriber Birthdate_____ Subscriber Home Phone _____ Subscriber Cell Phone_____

Subscriber Employed by_____Business Phone_____

Business Address_____ City_____ State_____ Zip_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. R. Scott Dickson, DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered. In understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship to Patient Date