Rancocas Woods
Family Dentistry

Patient Registration

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth: _____

Address: _____ City: _____ State _____ Zip: _____

Telephone (Mobile): _____ (Work): _____ (Home): _____

Employer: _____ Occupation: _____ Address: _____ Phone: _____

Email: _____ Emergency Contact: _____ Phone: _____

How did you hear about our practice? _____

Social Security # _____ Marital Status _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: Self Spouse Child Other	Relationship to Subscriber: Self Spouse Child Other
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone: _____	Insurance Phone: _____

Please present your insurance card to be copied for our records.

RESPONSIBLE PARTY

Last Name: _____ First: _____ Initial: _____

Address (If different): _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Work): _____ (Mobile): _____

Email: _____

Employer: _____ Occupation: _____ How Long employed at this job?: _____

Business Address: _____ Phone: _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS, I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____
(Responsible Party, if under 18)