Patient Registration Form

Patient Birthdate:

/ /

Patient Name ☐ F ☐ M

Last *First* *Middle Initial* *Preferred Name*

Address City State Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Cell number ( ) Home number ( ) email:

Do you prefer to be contacted via email, texting or telephone?

Employer Occupation Work phone ( )

Address City State Zip

Person responsible for this account

In case of an emergency, who should be notified? Phone ( )

How did you hear about this office?

Dental Insurance Information

Primary Dental Insurance ☐ yes ☐ no

Subscriber Name Relationship to Patient Subscriber DOB

Subscriber SSN/ID Group Number Subscriber Employer

Insurance Company Name

Insurance Company Address

Insurance Company Phone

Secondary Dental Insurance ☐ yes ☐ no

Subscriber Name Relationship to Patient Subscriber DOB

Subscriber SSN/ID Group Number Subscriber Employer

Insurance Company Name

Insurance Company Address

Insurance Company Phone

Insurance Authorization Statement (Sign and date)

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Carol M. Haddad all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance forms.

Responsible Party Signature Date

Relationship