# Patient Registration

## Personal Information (Patient)

Name _____ Prefer to be called _____

Address _____ City _____ ST/Zip_____

Home Phone _____ Work Phone _____ Cell _____

Best Number to Contact You? _____ Would you like email reminders? _____

Email _____Birthdate _____ S.S # _____

_____Male _____Female _____Child/Minor

Employer _____ Occupation_____

Referred to us by (relative,friend,website,etc.) _____

## Who is Responsible for Bill Payment (if other than patient or is a child)

Name _____Relationship to Patient _____

Address _____

Home Phone _____ Work Phone _____ Cell _____

Birthdate _____ S.S # _____ Email _____

Employer _____ Occupation _____

If Full-time College Student (Under Parents Insurance) Name of School _____

## Primary Insurance Information (please present us with your card for a copy!)

Name of Insured or Employee _____ Birthdate _____

S.S. # _____ Member ID or Subscriber ID # _____

Employer _____

## Secondary Insurance Information(note:most secondary plans pay insurance less insurance)

Name of Insured or Employee _____ Birthdate _____

S.S # _____ Member ID or Subscriber ID # _____

Employer _____

I understand that Martin Family and Cosmetic Dentistry are HIPAA compliant. I authorize the release of necessary information for insurance claim filing and the proper medical/dental treatment in the case it is needed. I also understand that I am responsible for all portions of my treatment in the event a third party payer remits less than estimated or expected. I will feel free to ask any staff member questions regarding my treatment.

**Signature** _____ **Date**_____