PATIENT REGISTRATION

First Name ______________________Middle Initial____ Last Name ________________________

Responsible Party (If someone other than patient) ___________________________

Street Address ____

City_________________________ State _______________________ Zip_______________

Home Phone________________ Work Phone___________________ Cell Phone_______________

Sex: ____Male ____Female ____Married ____Single ____Divorced ____Separated ____Widowed

Birth Date_____________ Social Security _____________________ Height/Weight _____________

Email ______________________________ Referred by________________________

Emergency Contact ________________Emergency Number _________________________

DENTAL INSURANCE

Primary Company__________________________________ Group #________________

I.D. Number from Insurance card (Required) ____________________________________

(if your insurance card has no ID number listed; enter your social security number)

Insurance Address____

Insurance Phone ____________________Subscriber________________________________

Relationship to patient _______________________ Date of Birth ____/____/_____

Subscriber's Employer ____

Employer's Address _____________________________Employer's Phone # _____________________

Your signature is necessary for us to process all insurance claims, to ensure payment for services rendered, and to release medical information to other providers, when necessary, for treatment. I authorize the release of certain protected health information (PHI) about me when necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical\dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Jay W Cook. This assignment will remain in effect until revoked by me in writing or expire on date of completed treatment. A photocopy of this assignment is to be considered as valid as the original. By signing this form you hereby accept responsibility to pay your estimated insurance co-payment at the time of service.

X Signature of Patient____Date____________