PATIENT REGISTRATION FORM

PATIENT NAME:_____

ADDRESS:_____ CITY, STATE ZIP:_____

PHONE (HOME): ( )_____ (WORK): ( )_____ (CELL): ( )_____

DATE OF BIRTH :_____ AGE:_____ PATIENT SOCIAL SECURITY #:_____

SEX: Male Female MARITAL STATUS: Single Married Other _____

SPOUSE OR NEAREST RELATIVE NAME:_____ PHONE:_____

ADDRESS:_____ CITY, STATE ZIP:_____

REFERRAL INFORMATION: WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Another patient, friend ___ Another patient, relative ___ Dental Office ___ Yellow Pages ___ Dental Insurance ___ Other ___

NAME OF PERSON, OFFICE, INSURANCE OR OTHER:_____

RESPONSIBLE PARTY INFORMATION:

RESPONSIBLE PARTY NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY, STATE ZIP: _____

PHONE (HOME): ( )_____ (WORK): ( )_____ (CELL): ( )_____

DATE OF BIRTH :_____ SOCIAL SECURITY #:_____ SEX: Male Female

EMPLOYMENT INFORMATION: The following is for: Patient ___ Responsible Party ___

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY, STATE ZIP: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INSURANCE CO NAME:_____

INS. CO. ADDRESS:_____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

ID #:_____ GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #: _____

SECONDARY INSURANCE

INSURANCE CO NAME:_____

INS. CO. ADDRESS:_____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

ID #:_____ GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the Dental Office of Bob DeMarco, D.M.D., 8877 West Union Hills Dr. Suite 600, Peoria, AZ 85382 for the dental benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize Bob DeMarco,DMD to perform diagnostic and therapeutic treatment necessary for proper dental care and to release any information required in the course of my treatment to other health care providers or third party payors.

PATIENT SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN:_____ DATE:_____

PATIENT INFORMATION