PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party **How did you hear about us?** _____

--**Responsible Party (If someone other than patient)** ----------

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip:_____ Pager: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Holder

-**Patient Information**----------

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip:_____ Pager: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

E-Mail: _____ ☐ I would like to receive correspondences via e-mail.

-**Primary Insurance Information (Policy Holder)** ----------

Policy Holder: _____ Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other

Policy Holder Social Security: _____ Policy Holder Birth Date: _____

Policy Holder Employer: _____ | Ins. Company: _____

Address: _____ | Address: _____

Address 2: _____ | Address 2: _____

City, State, Zip: _____ | City, State, Zip: _____

Rem. Benefits $_____ Rem. Deduct: $_____

-**Secondary Insurance Information (Policy Holder)** ----------

Policy Holder: _____ Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other

Policy Holder Social Security: _____ Policy Holder Birth Date: _____

Policy Holder Employer: _____ | Ins. Company: _____

Address: _____ | Address: _____

Address 2: _____ | Address 2: _____

City, State, Zip: _____ | City, State, Zip: _____

Rem. Benefits $_____ Rem. Deduct: $_____

PAYMENT IS DUE AT TIME OF SERVICE

For Deductible, Coinsurance, etc.

We offer several payment options: cash, check, Visa/Mastercard/American Express/Discover, Care Credit

Assignment and Release

I, the undersigned certify that I (or my dependent) have dental insurance coverage and assign directly to Neu Family Dental all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____ _____ _____

Responsible Party Signature | Relationship to Patient (if not patient) | Date