PATIENT REGISTRATION

Name: ______________________ Preferred Name: ______________________

Gender: ☐ Female ☐ Male Date of Birth: ____/____/____ Social Security #___-__-____

Address: ____
Street Address/ Box# City State Zip Code

Phone #s: Home ____________ Work ____________ Cell ____________

Referral: ☐ Paper ☐ Phone Book ☐ Facebook ☐ Website ☐Friend/Family, Who?________ Other ________

Responsible Party For Patient ______________________________

Adult Patients: ______________________________

Employer: ______________________ Phone# ______________________

Children's Names: ______________________________

In Case of Emergency, Contact ______________________ Relationship: ______________

Phone #s: Home ____________ Work ____________ Cell ____________

Maritial Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

For Patient Under 18 Years:

Father: Date of Birth: ___/___/___ Social Security # ___/__/____

Address: ____
Street Address/ Box# City State Zip Code

Phone #s: ☐ Home ____________ ☐ Work ____________ ☐ Cell ____________

Employer:______________________ Phone# ______________

Mother:______________________ Date of Birth:___/___/___ Social Security# ___/__/____

Address ____
Street Address/ Box# City State Zip Code

Phone #s: ☐ Home ____________ ☐ Work ____________ ☐ Cell ____________

Employer: ______________________Phone#: ______________

Parent's Marital Status ☐ Married ☐ Single ☐ Divorced With Whom Does The Child Live? __________

Dental Insurance Information: Policy Holder's Birthday ________ and Social Security # ____________

Primary: Subscriber: ______________________ Employer: ______________

Policy ID# ____________ Group ______________ Phone#______________

Claims Address:____
Street Address/ Box# City State Zip Code

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other, ______________

Secondary Policy Holder's Birthday ______________ and SS# ______________

Secondary: Subscriber: ______________________ Employer ______________

Policy ID# ____________ Group# ____________ Phone# ______________

Claims Address: ____
Street Address/ Box# City State Zip Code

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other, ______________

Financial Responsibility:

I hereby authorize Dr. Heath A. Robertson and/or Dr. James M. Hoover to release any and all of my medical (Including dental) information to my Insurance carrier (or to designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date signing until I revoke in writing. I understand that I may ask for a copy of this authorization. I have read this authorization and understood it. I hereby assign Dr. Robertson and Hoover all money to which I am entitled and/or dental expense relative to the services rendered by him (them), but not to exceed my Indebtedness to said doctor/surgeon. It is understood that any money recieved from my Insurance company, over and above my Indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to the above doctor(s) for charges not covored by this assignment. I further agree, In the event of non-payment, to bear the cost of collection, and/or court costs, reasonable legal fees, and also any finance charges and/or interest charged (18% APR).

______________________________________ | ______________

Responsible Party **Date Signed**