Patient Registration Form

Patient Information

Patient Name:_____ _____
Last MI First Preferred Name

Social Security Number:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell#:_____ Employer:_____

Ok to call work ☐ Yes ☐ No Work#:_____ Preferred # to reach you at:_____

Preferred appointment Times: ☐ Morning ☐Afternoon ☐Anytime ☐Mon ☐Tue ☐Wed ☐Thur

Spouse Name:_____

Referral Information

Whom may we thank for referring you to our practice? _____

Insurance Information

Name of Insured:_____SSN:_____ Birthdate:_____

Insurance Company:_____ Phone#:_____

Group/Plan Number:_____Employer:_____

Do you have secondary insurance: ☐ Yes ☐ No

Name of Insured:_____SSN:_____ Birthdate:_____

Insurance Company:_____ Phone#:_____

Group/Plan Number:_____Employer:_____

Emergency Information

Name of person to contact in case of emergency:_____

Phone Number:_____ Relationship:_____

Consent Form

As a courtesy, we will be happy to submit your insurance claim for you. Please let us know if any changes in your insurance occur. In order to prevent misunderstandings about our fees and your dental insurance, we want our patient to know that:

1. Your insurance coverage is a contract between your employer and your insurance company. There is no way we can know all of the plan benefits and provisions for all the different insurance companies. We will do our best to provide you with basic plan information.
2. In many cases, your insurance will pay only a part of your fees. We appreciate prompt payment of any patient portions at the time services are provided. I understand that I am financially responsible for any deductibles and non-covered services.
3. I authorize Jeffrey D. Pruiett D.M.D., to release any information requested by the insurance company with regards to payment of benefits.

I understand that, the information provided may be used for collection purposes. I authorize Jeffrey D. Pruiett D.M.D., or any collection agency to contact me by my cellular telephone for billing activities or payment arrangements.

Signature:_____ Date:_____