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Modern Dentistry with a Caring Touch

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Sex: ❑ M ❑ F	Birth date: / /	Age:	Social Security No.: / /	Home phone No.: ( )	Cell phone No.: ( )

Street address:	City:	State	ZIP Code:

Occupation:	Employer:	Employer phone No.: ( )

eMail:

If patient is a minor, please provide parent/guardian names and specify relation to the patient:

Referred to clinic by (please check one box):			❑ Dr. Name:		
❑ Family	❑ Friend	❑ Web Search	❑ Insurance Plan	❑ Hospital	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home phone No.: ( )	Work phone No.: ( )
Street address:	City:	State	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

If the patient is responsible for his/her bill, please skip the next section.
The guarantor is the person responsible for the patient's bill. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone No.: ( )

Occupation:	Employer:	Employer address:	Employer phone No.: ( )

Work related?	❑ Yes	❑ No	Auto Accident?	❑ Yes	❑ No	If yes, on what date did the injury occur?	/ /

Name of Primary Insurance:					
Subscriber's name:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of Secondary Insurance (if applicable):					
Subscriber's name:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

PHARMACY

Pharmacy name:	Pharmacy Address:	Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Tereza Hambarchian, DDS, Inc.** or insurance company to release any information required to process my claims.

/ /

Patient/Guardian signature	***Date***