HILLSBOROUGH PERIODONTICS & DENTAL IMPLANTS

Patient Registration

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

Name: Today's Date:

Last First MI

Email: Home Phone: Cell Phone:

Address: City: State: Zip:

Mailing address

Occupation: Business Phone: Height: Weight: Date of Birth: Sex: ☐ M ☐ F ☐ Other

SSN: Emergency Contact: Relationship: Emergency Contact Phone:

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

If you have DENTAL INSURANCE, please provide insurance information and sign below.

Insurance Information

PRIMARY Insurance Company: Address/City/State/Zip: Phone:

Subscriber Name: Date of Birth: Subscriber ID:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other

Employer Name: Plan/Group Name: Plan/Group Number:

SECONDARY Insurance Company: Address/City/State/Zip: Phone:

Subscriber Name: Date of Birth: Subscriber ID:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other

Employer Name: Plan/Group Name: Plan/Group Number:

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with dental services provided.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

Patient/Guardian Signature **Date** **Patient/Guardian Signature** **Date**