Bassett Creek DENTAL

Patient Registration Form

Account #

Patients Name ____________________________ SS# ____________________ Birth Date ____/____/____ Sex _____
How would you prefer to be addressed? ______________________________________
Responsible Party ____________________________ SS# ____________________ Relation to Pt ____________________
Address (Home) ____ City____________________ St_____ Zip________
Home Phone # __________________________ /Cell Phone # __________________________
Name of Employer_____________________Work Phone _________________ Spouse's Work Phone________________
E-mail Address ____

**** If College Student FT / PT School____________________________________ City_______________ St ______**

Insurance Coverage (Must have information in bold)	**Secondary Insurance Coverage**
Employee Name____________________________________	**Employee Name____________________________________**
Birth Date ____/____/____ SS# ______________________	**Birth Date ____/____/____ SS#_____________________**
Employer ____	**Employer ____**
Name of Ins. Co. ___________________________________	**Name of Ins. Co. ___________________________________**
Policy # ____	**Policy # ____**
Group # ____	**Group # ____**
Claim Billing Address ______________________________	**Claim Billing Address ______________________________**
Ins. Co. Phone # ____________________________________	Ins. Co. Phone # ____________________________________
Individual or Family Coverage ________________________	Individual or Family Coverage ________________________

Any other dental programs? ____

List other persons to appear on this account:

Full Name	Birth Date	Insured By
____________________________________	_____/_____/_____	______________________________
____________________________________	_____/_____/_____	______________________________
____________________________________	_____/_____/_____	______________________________

Emergency Contacts:

Name_______________________________ Address ____ Phone# ____________
Name_______________________________ Address ____ Phone# ____________

In consideration of the services rendered to me by this dental office, I am obligated to pay said dental office in accordance with its credit terms and policies. A copy of Bassett Creek Dental's credit terms and financial policies are available upon request. In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs at the rate of Thirty-Three percent of the balance due, along with reasonable attorney fees and court costs incurred by this office.

Patients Signature ____ Date ______________________________
If patient is a minor, guardian or parent, please sign.