Patient Registration

Patient Information:

First Name:____________________________________ MI:___________ Last Name:___________________________________

Physical Address:______________________________________ Address 2 (P.O. Box):__________________________________

City:____ State:_____________ Zip Code:__________________

Home Phone: _______________________ Work Phone:______________________ Ext:_____ Cellular:_____________________

Birth Date:____________________ Social Security:_____________________________ Drivers Lic:_______________________

(Payment in full by cash or credit card will be accepted if you choose not to provide this info.)

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Email:____ Employment Status: O Part-Time O Full-Time

Student Status: O Part-time O Full-Time Place of Employment:_____________________________

How did you hear about our office: O Yellow Pages O Dental Insurance O Other Source_____________________________

Referred By(other office or patient)____

Guarantor Information (Only if the patient is a minor, under 18 years old & the person who is with patient today):

First Name:___________________________________ MI:________ Last Name:_______________________________________

Address:____ Address 2:____

City:____ State:_____________ Zip Code:_________________

Home Phone:_______________________ Work Phone:_____________________ Ext. _____ Cellular:_____________________

Date of Birth:_________________ Social Security:_____________________________ Drivers Lic:________________________

(**Payment in full by cash or credit card will be accepted if you choose not to provide this info**.)

Relationship to Patient:_______________________________

Emergency Contact:____ Phone:____

Primary Insurance Information:

Insurance Company Name:___________________________________ Phone Number:___________________________________

Address:____ City:________________________ State:________ Zip:__________

Policy Holder:____ ID &/or SS#:____

(if your insurance company uses a separate ID#, please list)

Insured D.O.B.:_________________ Group#:_______________ Employer:____

I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT OR DULLY AUTHORIZED GENERAL AGENT TO FURNISH THE INFORMATION REQUESTED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ROCKY MOUNTAIN PROSTHETIC DENTISTRY, PC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS. I FURTHER UNDERSTAND THAT IT IS MY SOLE RESPONSIBILITY TO BILL ANY ADDITIONAL INSURANCES (SECONDARY INSURANCE) OTHER THAN MY PRIMARY FOR REIMBURSEMENT.

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SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE**