Bowman Family Dentistry

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Martial Status:

Is this your legal name? yes no	If not, What is your legal name?	Former name:	Birthday: / /	Age:	Sex: M F

Address:		
Social Security no: - -	Home Phone no:	Cell Phone no:
Occupation:	Employer:	Employer Phone no:

(please choose one option)

Chose clinic because:

Referred to clinic by:

Other family members seen here:

INSURANCE INFORMATION

(please give your insurance card to the receptionist.)

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

Is this person a patient here? yes no	Is this patient covered by insurance? yes no

Occupation:	Employer:	Employer address:	Employer Phone no:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no: - -	Birth date: / /	Group no.:	Policy no:	Co-payment

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work 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 Bowman Family Dentistry or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date