LIFELONG FAMILY DENTISTRY, PLLC

PATIENT REGISTRATION FORM

PATIENT INFO

FIRST/MIDDLE/LAST NAME			
HOME ADDRESS	**CITY**	**STATE**	**ZIP CODE**
EMAIL ADDRESS			
HOME PHONE #	**WORK PHONE #**	**MOBILE PHONE #**	
DRIVER'S LICENSE # / **DOB**	**SOCIAL SECURITY #**	**MARITAL STATUS**	
PRIMARY CARE PHYSICIAN	**EMPLOYER**		
EMERGENCY CONTACT	**EMERGENCY PHONE #**		
PHARMACY NAME	**PHARMACY ADDRESS & PHONE#**		

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18			
FIRST/MIDDLE/LAST NAME			
STREET ADDRESS			
HOME PHONE #	**DOB**	**SOCIAL SECURITY #**	
EMPLOYER NAME	**EMPLOYER PHONE #**		

INSURANCE INFO

PRIMARY INSURANCE			
PRIMARY INSURANCE NAME	**PRIMARY INSURANCE ADDRESS**		
SUBSCRIBER NAME	**EMPLOYER**	**DOB**	
SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**	
SECONDARY INSURANCE			
SECONDARY INSURANCE NAME	**SECONDARY INSURANCE ADDRESS**		
SUBSCRIBER NAME	**EMPLOYER**	**DOB**	
SUBSCRIBER ID #	**GROUP #**	**RELATION TO PATIENT**	

RELEASE

I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment without at least 24 hours prior notice, a fee will be charged. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to LifeLong Family Dentistry, PLLC, all dental benefits, if any, otherwise payable to me for services rendered. I hereby authorize the dentist and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient / Guardian: _____ **Date:** _____