

Patient Registration

PATIENT NAME (FIRST, MI, LAST) _____ BIRTH DATE ____/____/_____
 ADDRESS _____ CITY _____ STATE ____ ZIP _____
 MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced EMAIL _____
 HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ EMPLOYER _____
 PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____
 PERSON RESPONSIBLE PHONE _____ PERSON RESPONSIBLE EMAIL _____
 PERSON TO NOTIFY IN AN EMERGENCY _____ RELATIONSHIP _____
 EMERGENCY PERSON PHONE _____ EMERGENCY PERSON EMAIL _____
 HOW DID YOU HEAR ABOUT OUR OFFICE? _____

CONSENT

☐ ☐ May we leave a message on voicemail or an answering machine regarding treatment, appointments, or billing?
☐ ☐ May we give information regarding your treatment, appointments, or discussion of billing with anyone other than yourself? If so, complete below:
 INFORMED PERSON NAME _____ RELATIONSHIP _____

AUTHORIZATION

I hereby authorize the doctor to perform any forms of treatment, medication, and therapy which may be deemed necessary. I also understand that before treatment, the doctor and/or staff will give full explanation of the procedure(s) involved. I agree to pay for services rendered by this dental practice regardless of insurance.

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) _____ DATE ____/____/_____

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ BIRTH DATE OF INSURED ____/____/_____
 RELATIONSHIP TO PATIENT: ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Partner ☐ Other _____
 EMPLOYER _____ EMPLOYER PHONE _____
 INSURANCE _____ INSURANCE PHONE _____
 INSURED SOCIAL SECURITY NUMBER _____ EMPLOYEE ID _____ GROUP ID _____

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ BIRTH DATE OF INSURED ____/____/_____
 RELATIONSHIP TO PATIENT: ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Partner ☐ Other _____
 EMPLOYER _____ EMPLOYER PHONE _____
 INSURANCE _____ INSURANCE PHONE _____
 INSURED SOCIAL SECURITY NUMBER _____ EMPLOYEE ID _____ GROUP ID _____

ACKNOWLEDGMENT

I understand that as a courtesy to me, Dr. Corey Bickler's office will assist me in processing my insurance claims. However, I understand that **I am completely responsible for all fees**. I also understand that 48 hour notice is required for all appointment changes or a fee will be charged.

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) _____ DATE ____/____/_____
