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**