

ELIZABETH S. PITTMAN D.M.D.

REGISTRATION FORM

(Please Print-all field must be answered)

Today's date:					
PATIENT INFORMATION					
Patient's Name:			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Are you the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your name?	Relationship to Patient:		Patient Birth Date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security #:		Best # to reach you: ()	
City:		State/ Zip Code:		Email Address:	
Occupation/Student:		Employer:		Work Phone #: ()	
Referred to us by (please check one box):			<input type="checkbox"/> Family <input type="checkbox"/> Friend	<input type="checkbox"/> Insurance Directory	<input type="checkbox"/> Insurance Website
<input type="checkbox"/> Employee	<input type="checkbox"/> Co-Worker	<input type="checkbox"/> Walk In	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Name of person who referred you:					

FINANCIAL RESPONSIBILITY/INSURANCE INFORMATION					
(Please give your insurance card/cards and drivers license to the receptionist.)					
Person financially liable for charges: (If covered by insurance skip to A)		Birth Date: / /	Address :		Phone #: ()
<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Is this person you? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security #:	Employer:	Employer address:		Employer Phone #: ()	
A. Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance		<input type="checkbox"/> Delta Dental	<input type="checkbox"/> Guardian	<input type="checkbox"/> MetLife	<input type="checkbox"/> Aetna
<input type="checkbox"/> Humana Dental	<input type="checkbox"/> United Concordia	<input type="checkbox"/> Anthem	<input type="checkbox"/> Other	<input type="checkbox"/> Discounted Plan	
Subscriber's name:	S.S. #:	Birth date: / /	Group #:	ID #:	Effective Date: / /
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Social Security #:	Birth date: / /
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY			
Name of local friend or relative:		Relationship :	Phone #: ()
			Alternate #: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize the dentist or insurance company to release any information required to process my claims.</p>			
Patient/Guardian signature			Date