ELIZABETH S. PITTMAN D.M.D.

REGISTRATION FORM

(Please Print-all field must be answered)

Today's date:	

PATIENT INFORMATION

Patient's Name:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Are you the patient? ❑ Yes ❑ No	If not, what is your name?	Relationship to Patient:		Patient Birth Date: / /	Age:	Sex: ❑ M ❑ 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):	❑ Family ❑ Friend	❑ Insurance Directory	❑ Insurance Website			
❑ Employee	❑ Co-Worker	❑ Walk In	❑ Yellow Pages	❑ Other		
Name of person who referred you:						

FINANCIAL RESPONIBILITY/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 #: ( )	
❑ Parent ❑ Spouse ❑ Other	Is this person you? ❑ Yes ❑ No			Is this person a patient here? ❑ Yes ❑ No	
Social Security #:	Employer:	Employer address:		Employer Phone #: ( )	
A. Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Delta Dental	❑ Guardian	❑ MetLife	❑ Aetna	❑ Cigna
❑ Humana Dental	❑ United Concordia	❑ Anthem	❑ Other		❑ Discounted Plan
Subscriber's name:	S.S. #:	Birth date: / /	Group #:	ID #:	Effective Date: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Social Security #:		Birth date: / /	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship :	Phone #: ( )	Alternate #: ( )

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.

Patient/Guardian signature _____ *Date* _____