Reset | Print | E-Mail Form

ST. PETERSBURG DENTAL CENTER

Patient Registration

Responsible Party and Insurance Information

Date:

FIRST NAME: | MI: | LAST NAME: | NICKNAME:

ADDRESS: | CITY: | STATE: Select Or | ZIP:

EMAIL ADDRESS: | SOCIAL SECURITY NUMBER:

DRIVERS LICENSE NUMBER:

HOME PHONE:

WORK PHONE:

CELL PHONE:

SIGNED _____ DATE

Insurance Information

INSURANCE COMPANY INFORMATION

Name:

Address:

City:

State: Select Or Zip:

Plan / Group Number:

Employer Name:

SUBSCRIBER / POLICY HOLDER

Name:

Address:

City:

State: Select Or Zip:

Date of Birth:

Gender: MALE FEMALE

Subscriber Number:

I hereby authorize payment, directly to the doctor, of insurance benefits to which I am entitled.

POLICYHOLER: _____

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement and with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

POLICYHOLER: _____

EMERGENCY CONTACT

Name:

Address:

City:

State: Select Or Zip:

Phone Number:

RELEASE OF INFORMATION

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENTS OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES.

_____

SIGNED DATE

REVISED 2/09