PATIENT REGISTRATION

DATE________________

NAME ____ DATE OF BIRTH__________________

ADDRESS____ Circle: Male Female

CITY ____ STATE ________ ZIP_______________

HOME PHONE__________________ WORK _____________________ CELL______________________

OCCUPATION _____________________________ SOCIAL SECURITY # ________________________

EMPLOYER _______________________________ ADDRESS _________________________________

DENTAL INSURANCE CO. ____

SUBSCRIBER'S NAME ________________________________ DATE OF BIRTH__________________

SUBSCRIBER'S EMPLOYER ________________________ SS# or ID ___________________________

INSURANCE PHONE _____________________________ GROUP#____________________________

SECONDARY INSURANCE CO. ____

SUBSCRIBER'S NAME ________________________________ DATE OF BIRTH__________________

SUBSCRIBER'S EMPLOYER ________________________ SS# or ID# __________________________

INSURANCE PHONE _____________________________ GROUP#____________________________

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL INSURANCE CLAIMS. I HEREBY AUTHORIZE PAYMENT OF DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO DR. GREG ZLOCK.

SIGNATURE____

I ACKNOWLEDGE RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED AND AGREE TO PAY FOR THEM IN FULL. IF ACCOUNT BECOMES PAST DUE, THE ACCOUNT HOLDER IS RESPONSIBLE FOR 3RD PARTY OR AGENCY FEES. BY PROVIDING A MOBILE/CELL NUMBER, I AUTHORIZE THE USE OF CONTACT THROUGH THAT NUMBER FOR ANY ACTIVITY INVOLVING OUR SERVICES TO YOU, INCLUDING BUT NOT LIMITED TO THE RESOLUTION OF THE BALANCE OF YOUR ACCOUNT. THE NUMBER WILL NOT BE SHARED WITH ANY PARTY OTHER THAN THOSE IN-HOUSE OR ANY BUSINESS ENTITY CONTRACTED TO PERFORM DUTIES RESULTING FROM SERVICES PROVIDED TO YOU BY THIS OFFICE.

SIGNATURE____

NEAREST RELATIVE (not living with you) ____

PHONE ________________________ ADDRESS ______________________________________

WHOM MAY WE THANK FOR REFERING YOU TO OUR OFFICE?

NAME _________________________ ADDRESS ______________________________________