Patient Registration

Patient Information:

First Name:_____ Last Name_____ Middle Initial_____

Address:_____ Address 2:_____

City, State, Zip:_____Pager_____

Home Phone:_____ Work Phone:_____ Ext: _____Cellular:_____

Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

Sex: ☐ Male ☐ Female

Marital Status: _____Married _____Single _____Divorced _____Separated _____Widowed

E-mail:_____ I would like to receive correspondences via e-mail ☐

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

How did you hear about us? (name of person who referred you) _____

Responsible Party (if someone other than patient)

First Name:_____ Last Name_____ Middle Initial_____

Primary Insurance Information:

Name of Insured:_____ Insured Soc Sec:_____

Relationship to Insured: ____Self ____Spouse ____Child ____Other Insured Birth Date:_____

Employer:_____

Insurance Company:_____ Group Number:_____

Insurance Phone:_____ Policy Number:_____

Authorization:

- I authorize my insurance company to pay Canepa Dental all insurance benefits otherwise payable to me of services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize Canepa Dental to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all services provided to me and/or my dependent(s), regardless of insurance payments.
- I agree to pay all late and/or finance charges accrued on my account.

_____ _____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.