Westford FAMILY DENTAL PATIENT REGISTRATION

Basic patient Information

First Name: _____ M.I.: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ Sex: Male ☐ Female ☐

Home Address: _____City: _____State: _____ Zip: _____

Home phone #: (_____) _____ Work #: (_____) _____Cell #: (_____) _____

Employer: _____ Referred by: _____

Guarantor Information (Financially Responsible person)

First Name: _____Last Name: _____ Social Security: _____

Home Address: _____ City: _____State: _____ Zip: _____

Home Phone #: (_____) _____ Work Phone #: (_____) _____

Insurance Information

Primary Dental Ins. Name: _____ Ins. Address: _____

Telephone #: (_____) _____ City: _____State: _____ Zip: _____

Insured Party's First Name: _____ Last Name: _____ Insured Party's ID #: _____

Date of Birth: _____ Employer: _____ Group #: _____

Secondary Dental

Secondary Dental Ins. Name: _____ Ins. Address: _____

Telephone #: (_____) _____ City: _____State: _____Zip: _____

Insured Party's First Name: _____ Last Name: _____ Insured Party's ID #: _____

Date of Birth: _____ Employer: _____ Group #: _____

Medical Insurance

Insurance Name: _____ Ins. Address: _____

Telephone #: (_____) _____ City: _____State: _____ Zip: _____

Insured Party's First Name: _____ Last Name: _____ Insured Party's ID #: _____

Date of Birth: _____ Employer: _____ Group #: _____

Emergency Contact Information

Contact's Name: _____ Relation: _____

Telephone #: (_____) _____ City/State/Zip: _____

I authorize the release of all medical information to my insurance company, physicians, or dentist as deemed necessary in the professional judgement of my oral surgeon. I assign all insurance benefits which I am entitled, to Westford Family Dental. This assignment shall remain the effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand as the patient and/or responsible part that I am financially responsible for all charges, regardless of any insurance coverage I may have. I understand and agree that if the bill is not paid in full within 20 das of the services provided, I will be charged interest at the rate of 12% per annum, compounded monthly on any balance due and I will pay that as well as the balance due. In the event it should become necessary to place for collection any unpaid balance due, I agree to pay any collection. Legal, and/or court fees required in the collection process.

I HAVE COMPLETED AND READ THE INFORMATION ABOVE AND UNDERSTAND IT.

Patient: _____ Responsible Party: _____