# Patient Registration Information

*Welcome:* *Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print) Date _____

Name _____ Birthdate _____
First MI Last

Social Security # _____ E-Mail Address_____

Address_____ City_____ State_____ Zip_____

Home phone #_____ Work phone # _____ Cell phone # _____

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or Parent's name _____ Workplace _____ Work # _____

If you are a student, name of school/college _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

# Insurance Information / Person Responsible for Account

Name of person responsible for this account? _____

Relationship to patient _____Birthdate _____ Social Security# _____Driver License#_____

Phone # _____ Cellphone # _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Occupation _____ Work#_____ Ext _____

Employers Address _____ City _____ State _____ Zip _____

Insurance Company _____Group# _____ Insurance Co. Phone # _____

Have you used any dental benefits this year? ☐ Yes ☐ No If yes, how much used?_____

**Do you have an additional dental insurance plan?** ☐ Yes ☐ No If yes, please complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security# _____ Driver License#_____

Name of employer _____ Occupation _____ Work#_____ Ext _____

Employers Address _____ City _____ State _____ Zip _____

Insurance Company _____Group# _____ Insurance Co. Phone # _____

Have you used any dental benefits this year? ☐ Yes ☐ No If yes, how much used?_____

# Assignment and Release

**I, the undersigned certify that I (or my dependent) have insurance coverage. I assign to Frank A. Finazzo,D.D.S., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by my insurance.* I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**
**I have reviewed the information indicated on this questionnaire and it is accurate to the best of my knowledge.**

Signature _____ Date _____