PATIENT REGISTRATION

Welcome to our office. Please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: _____

Male/Female: _____ Date of Birth: _____ Soc. Sec. #: _____ Home Phone: _____

Mailing Address: _____ State: _____ Zip: _____

Residential Address: (if different): _____ State:_____ Zip: _____

Employer/School: _____ State: _____ Zip: _____ Phone:_____

Physician: _____ Referring Dentist: _____

Responsible Party's Information: (Person Accompanying Patient if a minor or disabled)

Relationship to patient: _____ Name:_____ DOB:_____

Phone number _____ Soc. Sec. # _____

Address: _____ State: _____ Zip: _____

Employer: _____ Address/Phone: _____

Dental Insurance Plan: _____ Phone: _____

Address: _____ Subscriber/Member ID: _____

Subscriber name: _____ DOB: _____ SS#: _____

Employer (name, address & telephone): _____

Medical Insurance Plan: _____ Phone: _____

Address: _____ Subscriber/Member ID: _____

Employer (name, address & telephone): _____

I have read and been offered a copy of the Privacy Policies of this office.

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information necessary to process my insurance claims. I assign all medical and /or dental benefits to which I am entitled to Granite State Oral Surgery, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for the entire cost of my/my dependent's treatment charges. I understand that I am responsible for any collections and/or attorney's charges, should a collection procedure be necessary. I have read this information and understand it.

Patient/Legal Guardian: _____ Date: _____

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