

REGISTRATION

Date: _____

Patient: _____ DOB: _____ SSN: _____ M/F

Address: _____

Status: S () M () D () W ()

Responsible Party:

Name: _____ DOB: _____ SSN: _____

Employer: _____ Employer Address: _____

Spouse: _____ DOB: _____ SSN: _____

Occupation: _____ Employer Address: _____

Whom May We Thank For Referring You? _____

Dental Insurance:

Policy Holder: _____ Relationship: _____

Insurance Company: _____ Group #: _____

Policy #: _____ Covered by additional insurance? Y/N

Subscriber's name: _____ DOB: _____ SSN: _____

Relationship: _____ Insurance Company: _____

Assignment and Release:

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. James W. Porter 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Date	Relationship
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Phone Numbers:

Home: _____ Work: _____ Cell: _____

Email: _____

In case of an **emergency**, contact: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____