PATIENT REGISTRATION FORM

Name ______________________________ Date ______________________

Home Phone (____)__________________ Work Phone (____) ____________

Address ___________________________ Cell/Pager (____) ____________

City ______________________________ State __________ Zip Code __________

Date of Birth ___ _________________ Spouse ______________________

E-mail Address ____________________

Single Married Divorced Widowed Separated Child Other ______________

Social Security # _________________

Occupation (Students give school name address) ______________________

Business/Employer ____

Business Address ____

Who may we thank for referring you?_____________________________

Primary Insurance Company:

Name of Insured Person ____________ Birth Date______________________

Employer___________________________ Social Security # _______________

Insurance Co. Name ________________ Ins. Co. Phone # (____)__________

Ins. Co. Address __________________ Policy/Group #__________________

___________________________________ Union/Local #___________________

___________________________________ Work Phone # (____) _____________

Secondary Insurance Company:

Name of Insured Person ____________ Birth Date______________________

Employer __________________________ Social Security #________________

Insurance Co. Name_________________ Ins. Co. Phone (____)____________

Insurance Co. Address _____________ Policy/Group # _________________

___________________________________ Union/Local #___________________

___________________________________ Work Phone # (_____) ____________

Authorization for Treatment/Assignment of Dental Insurance Benefits:

I authorize the dental office of Dr Paul E Szmyd DDS to perform diagnostic procedures and treatment as necessary for proper dental care.
I hereby assign all dental and/or emergency benefits, to which I am entitled, from private insurance, and any other health plan to Paul E. Szmyd DDS. This assignment will remain in effect until revoked by be in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.
I authorize Paul E Szmyd DDS to release any and all dental information (including medical information) to my insurance carrier for purposes of claims administration and audit. This authorization remains in effect until revoked by me in writing.
This is a contract and in the event a legal action becomes necessary to enforce payment for services rendered, the prevailing party shall be entitled to reasonable attorney fees and court costs.

Patient______________________________ Date__________________________
(Parent or Guardian if minor)