PATIENT REGISTRATION

Patient's Name _____Male_____Female_____

Date of Birth_____ SS#_____Single__Married__Divorced__Widowed__

Home Street Address _____

City_____ State_____Zipcode_____Email_____

Telephone Home_____Work_____Cell_____

If a child, parent or guardian name _____

If a student, name of school_____

Employer_____Postiton_____

Business Address: _____

Spouse _____ Date of Birth _____ SS# _____

Spouse Employed by _____ Work Phone#_____

Person responsible for account _____

Name of Dental Insurance Company_____Group/Policy #_____

Name of Insured_____

Insured SS# _____ID# _____Date of Birth _____

Why are you seeking dental treatment? _____

Who may we thank for referring you? _____

_____

_____

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family by the office of Scott Finlay, DDS & Associates.

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Scott Finlay, DDS & Associates. I clearly understand that it is my responsibility to make sure the account is paid in full. All co-pays and deductible are to be paid at the time services are rendered, if for any reason any expected portion of my bill is not paid by my insurance company I am responsible for the balance due within 30 days.

Signature of Patient _____Date_____

Signature of Insured _____Date_____