SANGER DENTAL
AT·THE·BASIN

REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Full Name: Preferred Name:	Birth date:	Age:	Sex: M F (circle one)
Address:	City:	State:	Zip:

Home Phone no.:	Work Phone no.:	Cell Phone no.:	Cell Phone Carrier: circle one Verizon AT&T Sprint T-Mobile Other:
Occupation:	Employer/ School:	Social Security no.:	Email:

How did you hear about us?

Other family members seen here:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:			Home phone no.:
Is this person a patient here?	Yes No (circle one)	Is this patient covered by insurance?	Yes No (circle one)

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Insurance ID no.:	Group no.:

Subscriber's Employer: Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Insurance ID no.:	Group no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of contact: Relationship to patient: Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Sanger Dental at the Basin. I understand that I am financially responsible for any balance. I also authorize Sanger Dental at the Basin or insurance company to release any information required to process my claims.

Patient/Guardian signature Date