**PATIENT REGISTRATION**

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

|  |
| --- |
| DATE |
| NAME |
| SPOUSE |
| ADDRESS |
| CITY PROVINCE POSTAL CODE |
| HOME PHONE NO. WORK PHONE NO. CELLPHONE NO. |
| BIRTHDATE AGE |
| MARRIED SINGLE DIVORCED WIDOWED |

**GETTING TO KNOW YOU**

 Is another member of your family or relative a patient at our office? YES / NO

 If yes, their name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Referred to us by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If no, how did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

|  |
| --- |
| NAME: RELATIONSHIP TO YOU: |
| TELEPHONE NO. |
| ADDRESS |
| CITY PROVINCE POSTAL CODE |

**DENTAL INSURANCE**

|  |
| --- |
| PRIMARY INSURANCE |
| PLAN# |
| ID# |
| A % B % C % |
|  |
| SECONDARY INSURANCE |
| PLAN # |
| ID# |
| A % B % C % |
|  |

I understand Dr. Michael Sretavan’s dental office will try to find out as much information as possible from my dental insurance, but with the privacy laws,I also realize that insurance companies do not always release information to them. **I will therefore be fully responsible for the fees that are not paid by my dental insurance.**

To expedite the payment process, I hereby also authorize Dr. Michael Sretavan’s dental office to submit all my dental insurance claims as well as any dental pre-authorizations electronically to my insurance company.

 Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_