Facial Spectrum, Inc.
PATIENT REGISTRATION

Date: ________________

Patient: (Mr., Mrs., Ms., Dr.) First Name____________________ M.I._____ Last Name_____________________________ Nickname________________

Sex: [ ] Male [ ] Female Birth Date______________ Age______ Social Sec. # _________________________ Email_________________________

Street____ City____________________________ State________ Zip Code ___________________

Home Phone________________________ Work Phone____________________ Cell Phone______________________ Pager_____________________

Dentist____ Physician ____

Driver's License #________________________ Emergency contact____________________ Phone_____________ Address _____________________

Who referred you to this office? _________________________ Have you ever been a patient in our office? [ ] Yes [ ] No When?____________

How did you hear about us? __ patient referral __magazine ad __newspaper ad __phone book __web __reputation __other

Would you be interested in being contacted for special offers and events? __no __ yes (please provide e-mail address _____________________________)

Who will be responsible for your account? [ ] Self [ ] Spouse [ ] Father [ ] Mother [ ] Other _______________

Name____ Soc Sec # ______________________________ Home Phone _____________________

Street____ City_____________________________ State________ Zip Code ___________________

Employer Name_________________________________City____________________________State_______Zip________ Phone __________________

Name of Spouse or Parents_________________________________ Soc Sec # _________________________ Home Phone ____________________

Street____ City_____________________________ State________ Zip Code ___________________

Employer Name_________________________________City______________________________State_______Zip________ Phone ________________

INSURANCE INFORMATION

Patient: Student: [ ] Full Time [ ] Part Time [ ] Not School Name/Address ____

Married: [ ] Married [ ] Divorced [ ] Separated [ ] Widow [ ] Single

Employed: [ ] Full Time [ ] Part Time [ ] Retired [ ] Not Do you belong to a PPO or HMO?________

Primary Dental Insurance

Employer ____

Bus. Address____

Bus. Tel #___________________ Plan ____________________

Ins. Co. Name_______________________________________

Street____

City/St/Zip __________________________Phone____________

Group #___________________**Group Name**_______________

Policy Holder________________________Relation___________

Date of Birth ______________ SS# _______________________

Street____

City/St/Zip __________________________Phone____________

ID Number____

Primary Medical Insurance

Employer ____

Bus. Address____

Bus. Tel #___________________ Plan ____________________

Ins. Co. Name_______________________________________

Street____

City/St/Zip __________________________Phone____________

Group #___________________**Group Name**_______________

Policy Holder________________________Relation__________

Date of Birth ______________ SS# _______________________

Street____

City/St/Zip __________________________Phone____________

ID Number____

Secondary Dental Insurance

Employer ____

Bus. Address____

Bus. Tel #___________________ Plan ____________________

Ins. Co. Name_______________________________________

Street____

City/St/Zip __________________________Phone____________

Group #___________________**Group Name**_______________

Policy Holder________________________Relation__________

Date of Birth _______________ SS# ______________________

Street____

City/St/Zip__________________________Phone_____________

ID Number ____

Secondary Medical Insurance

Employer ____

Bus. Address____

Bus. Tel #___________________ Plan ____________________

Ins. Co. Name_______________________________________

Street____

City/St/Zip __________________________Phone____________

Group #___________________**Group Name**_______________

Policy Holder________________________Relation__________

Date of Birth _______________ SS# ______________________

Street____

City/St/Zip__________________________Phone_____________

ID Number ____

All professional services provided are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient (or parent, if minor child) is responsible for all fees, regardless of insurance coverage. It is expected that all fees will be paid at the time of services unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION / FINANCIAL RESPONSIBILITY

I authorize the release of any medical/dental information necessary to process my insurance claim. I also request payment of government/private insurance benefits to the doctor. I understand that I am responsible for my total bill, including any portion of those charges not covered by my insurance plan. I also agree that I am responsible for all billing collection charges for any overdue or unpaid account.

Date _________ Signature (Patient) ____________________________________Guarantor ____

(If patient is a minor, parent or legal guardian must sign)